

Maternal and Child Health Services Title V Block Grant

State Narrative for Colorado

Application for 2014 Annual Report for 2012



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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The Appropriate Assurances and Certifications for non-construction programs, debarment and suspension, drug-free work place, lobbying, program fraud, and tobacco smoke, that are part of this grant, are maintained on file as required by the block grant guidance at the State's MCH administrative office on the fourth floor at the Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South, Denver, Colorado 80246.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

Colorado first placed online for review and public input its FY 2000 Maternal and Child Health Block Grant in 1999. Since that time, all narratives have been placed online. Users find online access to the grant very convenient, and comments throughout the year are solicited through a return email function on the Web site.

Much input was sought last year for the FY 2011 grant application through the intensive needs assessment process that was conducted. This process was described in detail in the needs assessment section (Section II).

A draft version of the FY 2011 grant application was placed on the state health department's Web site on July 1, 2010. The MCH Director sent a letter to key stakeholders informing them that comments were

welcome. Appropriate changes were made in the final grant application before the July 15, 2010 submission.

After transmittal to the Maternal and Child Health Bureau, the final version of the Maternal and Child Health Application/Annual Report for FY 2011 will be available on the department Web site. Visitors to the Web site will be able to download the application and will be able to email the Division with their comments and questions throughout the year. Hard copies will also be available. A map of Colorado is attached to this section to assist the reader when county and place name references are used in the grant application.

/2012/ Multiple forums were held throughout 2010 and 2011 to gather input on Colorado's Block Grant application

and the new MCH priorities. An effort was made to include multiple stakeholders, along with feedback from family

leaders. Presentations/discussions included an MCH Stakeholder meeting in September 2010, a

webinar in

October 2010, an Early Childhood Stakeholders meeting in November 2010, a presentation to the Colorado

Association of Local Public Health Officials (CALPHO) and the Colorado Association of Public Health Administrative

Directors (CoPHAD) in December 2010 and a review of the new priorities at the Health Integration Summit for

Early Childhood Councils in January 2011. Health care professionals and interested staff were addressed at a

presentation given at The Children's Hospital in May 2011.

In addition, the State Planning Team for the Family Leadership Training Institute (FLTI), which includes

representation from six urban/rural counties (Adams, Arapahoe, Larimer, Montezuma, Dolores and Denver),

discussed the Block Grant at team strategic planning meetings in October 2010 and April 2011. Input was also

solicited from the Family Voices Executive Director during monthly "check in" calls. Discussion around the Block

Grant and the new priorities was also featured at meetings with the Medical Home Advisory and Steering

Committee members during the current grant year.

Overall, participants at the meetings provided positive feedback on the priorities. Discussions allowed all involved

to share current activities occurring around the state, as well as brainstorm ideas and develop new partnerships

for future activities. Specific feedback is summarized in the following sections focused on the National (NPM) and

State Performance Measures (SPM). A full report from the September 2010 stakeholder meeting is available online

(www.cdphe.state.co.us/ps/mch/mchresources/MCH Stakeholder Meeting note summary.docx)

In addition, input received at the early childhood stakeholder's meeting in November 2010 highlighted the

importance of encouraging similar conversations about the MCH priorities between local public health and local

early childhood councils, with state staff facilitation.

Stakeholder feedback has been shared with each MCH Implementation Teams for incorporation into the public

health planning process.

The draft and final copy of the FY2012 application will again be posted online. //2012//

/2013/ The Colorado MCH Program engages stakeholders intentionally and routinely in both program planning,

implementation and evaluation efforts. One primary focus of Colorado's MCH Program this year has been moving

from the identification of the MCH priorities towards the implementation of evidence-based strategies, or data to

action. For more detail on this process, please see the Needs Assessment update. Throughout the data to

action process, the MCH Implementation Teams (MITs) engaged a variety of stakeholders in multiple ways to

solicit feedback that would inform their state and local logic model and action plan development,

including the

selection of coordinated state and local public health strategies targeting Colorado's MCH priorities. Some MITs

engaged stakeholders through ongoing participation on the implementation teams. Other MITs created advisory

groups to guide their work and solicited input periodically through focus groups, summits, or material review.

Internal and external stakeholders were involved throughout this process including representatives from the

health care sector; insurance industry; Departments of Education, Transportation, and Human Services; other

CDPHE programs such as STD/HIV prevention and chronic disease; community-based organizations; and

families/youth. In addition, the MITs were required to engage local public health agency staff members in action

plan development given local MCH staff are charged with implementing the local action plans in their communities.

Given the variation on stakeholder engagement efforts across the nine MITs, several examples are cited here in

greater detail. In August 2011, the Maternal Wellness team hosted a summit bringing together 64 stakeholders

from across the state to determine 1. Current efforts in place related to preconception health and pregnancy-

related depression; 2. Ascertain successful population-based efforts; 3. Suggestions for what changes around

preconception health and pregnancy-related depression are needed in Colorado; and 4. Identify Colorado

strengths that support preconception health and pregnancy-related depression efforts. Summit attendees

represented local public health agency staffs, academia, multi-disciplinary medical professionals, and state public

health department staffs.

Maternal Wellness Preconception health and pregnancy-related depression advisory committees were formed

through an application process. Members were selected based on the need for diverse perspectives and multi-

disciplinary knowledge and skill. Advisory committees consist of members from the state public health agency,

local county public health agencies, academia, medical professionals, mental health professionals, social work

professionals, health plan staffs, and non-profit organization staffs. Advisory Committees meet every quarter to

discuss activity plan strategies and activities. In addition, committee members highlight their work related to

preconception health and pregnancy-related depression.

The Youth Sexual Health MCH Implementation Team pulled together four state staff, including one MCH

Generalist, and eight local public health champions from urban, rural and frontier communities to gather their

input and feedback on both the state and local logic models and action plans. Participants were actively involved

throughout the three hour meeting, breaking into small groups based on each strategy and discussing whether

each one was population-based, feasible, a public health role, etc. The MIT Leads then incorporated the local

feedback and finalized the state and local logic models and action plans.

The Colorado MCH Program revised its local funding model this past year, in part, to better align local funding to

support work on the MCH priorities (see the Needs Assessment update for more information). Local public health

stakeholder engagement was an integral component of this intensive, year-long initiative. To this end, 112 local

public health agency staff members participated in two webinars conducted in October 2011. Twenty local staff

responded to an on-line survey following the webinar with questions and comments. In November 2011, state

MCH staff facilitated six regional meetings in Durango, Grand Junction, Eagle, Fort Morgan, Pueblo, and Metro

Denver to discuss the proposed funding changes. Thirty-three out of the 55 LPHAs attended and provided

feedback both on the proposed funding formula as well as on what would be reasonable contract expectations

for different levels of funding. From December 2011 through March 2012, state staff facilitated two local health

agency workgroups, with 8-12 members each, who informed decisions related to MCH program operations, as

well as local funding expectations and guidance. Final local funding decisions were shared and discussed in two

webinars held in late February/early March with 100 local health agency staff participating. A question and

answer session was included. Finally, 150 local public health agency staff participated in a 2.5 day conference in

March whereby priority strategies and funding expectations were highlighted in an interactive and engaging

environment. A LPHA agency work group will continue to meet to assess the impact of local funding changes, as

well as provide feedback for program operations.

Based on input from local communities, the Youth Sexual Health Team worked with Colorado Youth Matter to

complete a statewide youth sexual health "call to action," called Youth Sexual Health in Colorado: A Call to Action.

For more information, see NPM 8 and SPM 8.

For more information about input provided to MCH by Colorado families see NPMs 2 and 6.

The draft and final copy of the FY2013 application will be posted online on CoPrevent (http://www.coprevent.org),

Colorado's prevention-related news and information site hosted by the Prevention Services Division (PSD) of

CDPHE. The final version will also be posted on the MCH website (www.mchcolorado.org). //2013//

/2014/ The Colorado MCH Program continues to engage stakeholders in the state and local work of the nine MCH Implementation Teams (MITs).

In the fall of 2012, CDPHE released Youth Sexual Health in Colorado: A Call to Action,

Colorado's effort to address

youth sexual health as a holistic issue (see NPM 8 and SPM 8). Input for the Call to Action was gathered through

urban and rural community conversations, youth and parent focus groups, youth interviews and a statewide

community survey (with over 700 responses and representation from 52 of Colorado's 64 counties). The Call to

Action was developed in partnership with youth, as two youth leaders and two interns were part of the project staff.

Colorado9to25 (CO9to25), a youth development group, was officially launched (see SPM 10). A youth lead the

planning and facilitating of the launch and there were 61 diverse youth, between the ages of 9 to 25 present at

the launch (in addition to the 75+ adults).

CDPHE continues to provide leadership for the Colorado Medical Home Initiative (CMHI) in collaboration with

Health Care Policy and Financing (see NPM 3). The Colorado Medical Home Community Forum, a bi-monthly

meeting of Colorado stakeholders representing various state and local agencies, families, health care providers

and policymakers continues with about 50 stakeholders participating.

Stakeholders were involved with CDPHE's Early Childhood Obesity Prevention (ECOP) Message Testing Project

which explored messages targeting women (see SPM 2), pregnant women (see SPM 6), and families of young

children (see NPM 14). Over 200 stakeholders from WIC, home visitation programs, early care and education

groups, and health care organizations provided feedback. The messages were tested in focus groups comprised

of the MCH population. Finally, a work group revised the messages according to results.

The draft and final copy of the FY2014 application will be posted online on CoPrevent, the Prevention Services

Division's external Web site (http://www.coprevent.org). The final version will also be posted on the MCH website

(www.mchcolorado.org). //2014//

II. Needs Assessment

In application year 2014, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

Colorado's focused its efforts this year on the oversight, implementation, and support of evidence-based strategies

at the state and local level. In 2011, MCH Implementation Teams (MITs) developed coordinated state and local

action plans for each MCH priority that included evidence-based and population-based goals, objectives, and

activities. In 2012, state MCH staff began implementation of the state-level action plans. Progress on each of the

plans and state performance measures is referenced in the state performance measure narratives.

In order to assure the implementation of state action plans with fidelity, the MCH Steering Team continues to

provide oversight and support to the effort. The Steering Team implemented several mechanisms in the past year

to monitor implementation efforts with the intention of assuring progress on the plans, to assist state staff with

problem-solving as implementation challenges arose, as well as to identify areas for capacity-building and support.

For example, MITs visited the Steering Team meetings two times in 2012, and once in 2013. At these meetings.

state staff presented on their progress and challenges. Both Steering Team members and MITs asked questions of

one another to better understand efforts and expectations.

In September 2012, the MCH Steering Team also coordinated and facilitated a full-day retreat with all MITs where

each team presented on their 2012 work. The purpose of this retreat was for the Steering Team to learn and

monitor efforts as well as to foster learning among the MITs about one another's efforts and to promote the

horizontal integration of efforts.

Finally, MITS were asked to develop an annual update for 2012 that summarized their state-level efforts. These

reports were shared with local public health agency staff as a communication and informationsharing tool, given

state and local staff members are working on the same MCH priorities.

The MCH Steering Team supported MITs by developing an enhanced communication and information sharing system

using the Google platform; researching, developing, and sharing a summary document highlighting the pros and

cons of multiple collaboration evaluation tools; and identifying and designing a learning opportunity with a national

technical assistance provider on how to effectively facilitate webinars.

Early in 2013, MITs revised their state-level action plans to reflect changes for year two of

implementation. The

MCH Steering Team will continue to monitor and support state-level MCH priority implementation efforts.

With the 2012 alignment of MCH population-based programs under the Children, Youth and Families (CYF) Branch

(see III. State Overview, C. Organizational Structure), MCH leadership revisited membership of the MCH Steering

Team, and membership was adjusted accordingly. The Health Care Program for Children and Youth with Special

Needs Unit Manager, Jennie Munthali, and the Population and Community Health Unit Manager, Anne-Marie Braga,

joined the Steering Team. The State MCH Director, Karen Trierweiler; the CYF Branch Director, Rachel Hutson; and

the MCH Unit Manager, Gina Febbraro, continue to participate on the MCH Steering Team.

The fourteen local public health agencies (LPHAs) receiving greater than \$50,000 annually in MCH funding

participated in an intensive planning process to identify the MCH priorities and local action plans that best align with

their agency and community priorities and needs. Agency priority selections are identified in the LPHA MCH priority

matrix (attached). Agencies were required to spend 10% of their MCH funds on implementation of the MCH priority

action plans. Most agencies chose to allocate a majority of their funds to working on the MCH priorities, far

exceeding the 10% requirement. With the start of the FY12 funding cycle in October 2012, LPHAs began

implementation of MCH priority efforts.

The MCH Generalist Consultants, in partnership with the MITs, provide ongoing support and monitoring of LPHA

efforts. The MCH Generalist Consultants provide technical assistance and consultation through progress check-in

meetings three times per year and other individual consultation meetings. They monitor local agency performance

through these meetings in addition to invoice review and annual reporting. The MITs provide support to local

agencies through individual consultation as well as by facilitating learning circles for those agencies working on their

priority area. To date, 11 learning circles have been implemented with excellent participation from local staff.

In March 2013, state MCH staff coordinated and hosted a two-day conference for LPHAs that supported

implementation of their efforts. Over 140 state and local public health agency staff participated in the 2013 Maternal

Child Health Conference: Building Community Partnerships to Impact Health Outcomes. Conference plenary and

breakout sessions included a national policy update by Mike Fraser, a session on Colorado's MCH strategic direction.

engaging families as partners, building and sustaining effective coalitions and partnerships, and MCH priority local

action plan guidance. There was a HCP conference track addressing HCP Care Coordination and HCP program

implementation. In addition, there were 20 roundtable sessions conducted that provided an opportunity for CDPHE

and LPHA resource sharing and informal networking. Plenary and breakout session resources are posted on the

MCH website at www.mchcolorado.org.

Colorado MCH staff presented on the 2010-2012 data to action process and lessons learned at the 2012 Public

Health of the Rockies conference and the 2012 CityMatch conference. Colorado MCH and Epidemiology, Planning

and Evaluation (EPE) staff also submitted a manuscript on the data to action process to the Journal of Maternal and

Child Health.

In addition to implementation of priority-related efforts, Colorado initiated several steps in preparation for the 2015

needs assessment process: developing MCH epidemiology issue briefs and soliciting information on other state-

level needs assessment efforts in Colorado.

In previous years, state MCH staff invested countless hours and resources to produce a Health Status Report on the

MCH population. This 180+ page document included a comprehensive array of health indicator data that described

the health status of the MCH population. State MCH staff conducted a web-based survey of users to solicit

feedback on the frequency and ease of use of the health status report. Data suggested that the report was not

used widely, and when it was used, it was often by students. The intent of the document was to both inform the

needs assessment process and to serve as a resource to public health professionals.

As a result of the feedback, state MCH staff decided to adopt a new approach to collecting and summarizing

important MCH indicator data. The new approach is not only intended to be more user-friendly but also to serve as

an ongoing monitoring and surveillance tool. The MCH Program Specialist worked with EPE Branch staff to design a

three- to four-page template that includes the following components for identified MCH issues: incidence and

prevalence, social determinants of health, other contributing factors, and a summary. Three briefs have been

produced and disseminated to date: unintended pregnancy, infant mortality, and maternal and early childhood

obesity (attached). The EPE Branch also worked with Health Statistics to create a Health Watch on medical home

among Colorado children that includes disparity data (attached).

Colorado's MCH Program was selected to host a Graduate Student in Epidemiology this summer. The intern will work

on producing three more issue briefs: mental health in child/adolescents, mental health in women, and child and youth injury.

In addition to producing MCH epidemiological issue briefs, MCH leadership initiated discussions with other Colorado

stakeholders to learn what recent or new needs assessment processes are being conducted. CDPHE's Office of

Planning and Partnerships will be working collaboratively with others in the Department to complete a statewide

health assessment in order to apply for accreditation. They shared their plan and methodology with MCH staff. The

MCH Program intends to leverage their efforts and utilize appropriate and relevant products from their statewide

needs assessment to inform Colorado's 2015 MCH needs assessment. State MCH staff also knows that by this

year, the 55 LPHAs in Colorado will have completed their community health assessments and public health

improvement plans. Data, such as public health priorities, aggregated from these assessments will also inform the

2015 MCH needs assessment process.

An attachment is included in this section. IIC - Needs Assessment Summary

III. State Overview

A. Overview

Introduction

This section discusses the Colorado's health care delivery environment. It also provides an overview of the factors

impacting health services delivery such as: poverty, racial and ethnic disparities and geography. More detailed

analysis of these factors and others are found in the needs assessment section. The needs assessment section

also delineates how these factors were analyzed within the process that led to the identification of the nine

Colorado MCH priority areas.

For the Colorado needs assessment and planning process, the state used a conceptual framework that integrated a

strengths-based approach with the goal of optimizing health and well-being among the MCH population across the

life course. The approach took into account that a complex interplay of biological, behavioral, psychological, and

social factors (e.g., both risk and protective) contribute to health outcomes (e.g., the Life Course Health

Development Model). In alignment with this model, the influence of early life events (early programming) and critical

periods across the life course were considered with attention given to the cumulative impact of experiences over

time, which resulted in an emphasis on primary prevention and early intervention. The social determinants of health

were also considered as factors that shape the health of individuals and communities.

For purposes of assessment and strategic planning, the MCH population was defined as women, children,

adolescents, children with special health care needs, and families. The MCH population was further subdivided into

women of reproductive age (ages 15-44), early childhood (ages birth-8), including children with special health care

needs and child/adolescent (ages 9-21), including children and youth with special health care needs.

The needs assessment process focused on identifying a set of specific priorities that could be acted upon at some

depth so that results, even preliminary ones, would be achievable and evident in five years. Strategies employed to

achieve results were to be evidence-based/ promising practices or interventions grounded in sound public health

theory or research and consistent with the mission and scope of Colorado's MCH program. A clear MCH public health

role needed to exist for an issue to be considered as a potential priority.

In the beginning stages of the Colorado's needs assessment, two strategies were used to solicit both qualitative

and quantitative data to identify potential MCH priority areas. The first strategy involved convening groups of

subject matter experts. The second Phase I strategy involved creating an updated version of the Colorado MCH

Health Status Report, which served as a means for compiling and analyzing quantitative MCH population data.

Geography

The Rocky Mountain state of Colorado is bounded on the east by Kansas and Nebraska, on the north by Nebraska

and Wyoming, on the west by Utah and on the south by New Mexico and Oklahoma. Colorado is the eighth largest

state when measured in square miles and consists of different regions of mountains, plateaus, canyons and plains.

Generally, the eastern half of the state has flat, high plains and rolling prairies that gradually rise westward to the

Front Range foothills and the higher ranges of the Rocky Mountains. Colorado has the highest mean elevation of any

state with more than a thousand mountain peaks over 10,000 feet high including 54 that are over 14.000. The

Continental Divide runs from north to south through west central Colorado and bisects the state into the eastern

and western slopes.

The state can be divided into five distinctive regions within its 64 counties: the Front Range, the Western Slope, the

Eastern Plains, the Central Mountains, and the San Luis Valley. Each of these areas grew in population between

2000 and 2007, ranging from a 3 percent increase in the Eastern Plains to an 18 percent increase on the Western

Slope. Close to 85 percent of the population lives in urbanized areas and 82 percent of the population lives in the

Front Range, which includes the metropolitan areas of Denver-Boulder, Ft. Collins, Greeley, Colorado Springs, and

Pueblo. The San Luis Valley in the southern part of the state is the region with the smallest population, with about

48,000 residents. The rural vastness of much of the state is confirmed by 20 of Colorado's 64 counties which qualify

as frontier counties containing fewer than 6 persons per square mile; of these 20, eleven have 2 or fewer persons per square mile.

Population

Colorado, ranking 22nd among states based on the size of its population, has had one of the fastest growth rates

of all states. The overall population for Colorado in 2010 is projected to reach over 5 million-5,218,146; this

projection is an increase of over 10 percent since 2005, when the estimated Colorado population was 4,731,787

residents. By 2015, the population is projected to increase by another 10 percent, reaching 5.737,307.

Population growth is determined by the number of resident births, deaths, and migration into the state. The ratio of

births to deaths has consistently averaged over twice as many births as deaths in a given year. Between 2000 and

2008, the number of Colorado births increased by just 7 percent, reducing the very rapid growth in the total number

of births that had been seen in the decade of the 1990s. In 2000 there were 65,000 births; the number of births

has risen since then but remained at approximately 70,000 annually between 2006 and 2008. Preliminary estimates

for 2009 actually suggest a decline to about 68,600. A drop this substantial can be attributed in large part to the

downturn in the economy.

Women between the ages of 25 and 34 consistently contribute over 50 percent of births each year; in addition,

women in this age group have not shown any decline in fertility rates in the past decade in contrast to the

experience of younger women. Thus, the expected growth of women who are age 25 to 34 in the coming years will

have a significant impact on the need for maternal and infant services and supports.

While the number of deaths annually has risen, both the crude and adjusted death rates have fallen since 2000. It

is important to note as well that migration has been an important factor in the state's population growth in recent

years. Between 2000 and 2008 net migration (the total number of people moving to the state minus the number

leaving) exceeded 433,000 people. Between 2009 and 2012, net migration is expected to account for over 50

percent of the increase in total population, with an additional 143,000 residents arriving.

The two major racial and ethnic groups in Colorado are composed of White non-Hispanic persons and persons of

any race who are of Hispanic origin or ethnicity. Estimates from the American Community Survey (2008) of the U.S.

Census Bureau show that 70.9 percent of Coloradans identify themselves as White non-Hispanic and 20.2 percent

identify themselves as of Hispanic origin. Non-Hispanic groups include African-American/Black (3.6 percent), Asian

and Pacific Islander (2.6 percent), American Indian (0.6 percent) and people who report other races or more than

one race (2.2 percent).

The Hispanic population has grown rapidly in recent years; from 735,601 in 2000 to an estimated 963,831 in 2006-

2008 according to the most recent three-year estimates available from the American Community Survey. The vast

majority of the Hispanic population is of Mexican descent, while virtually all the rest is from Central and South

America. Over 71 percent of the Hispanic population in Colorado was born in the United States; 29 percent was not.

Almost 16 percent of those born outside the U.S. are naturalized citizens.

Approximately 17 percent of Colorado residents age 5 and older speak a language other than English at home; over

70 percent of those speaking another language in the home speak Spanish. Four percent of households in

Colorado are estimated to be linguistically isolated, i.e., all members 14 years and older have at least some difficulty with English.

Education

Colorado has an educated population. Over one-third (34.6 percent) of all Coloradans age 25 and

older have a

college degree or more and Colorado is ranked 4th among all states and the District of Columbia in the percentage

of the population with a college degree. Educational attainment varies by race and ethnicity in Colorado; 46 percent

of Asian/Pacific Islanders have a college degree or more as do 40 percent of White, non-Hispanics, 22 percent of

African Americans/Blacks, and 11 percent of Hispanics. The high rate of college graduates in the state is reflected in

the work force in Colorado; Colorado's economy has been based on employment in the service-based industries for

more than six decades. The service-based industries cover a wide range of businesses that do not produce tangible

goods and include professional, scientific, technical, managerial, administrative, educational, health care and social

assistance, and accommodation and food services.

Income and education are highly correlated. Eighty-one percent of all low-income children come from families where

parents had less than a high school education. The poverty rate for Coloradans age 25 and older who do not have

a high school diploma is 23 percent compared to just over 3 percent for those with a college degree or higher.

While the prevalence of college graduates in Colorado is high, the percentage of high school students who graduate

is relatively low. This state of affairs exists because many highly educated people migrate to Colorado after

completing their education; they have completed at least high school elsewhere. High school graduation rates for

Colorado for 2006, 2007, and 2008 show only three-fourths of Colorado's students who started 9th grade are

known to have graduated from high school within four years. A Healthy People 2010 objective is to increase high

school completion to 90 percent, and Colorado's students fall far short of the target.

Disparities in graduation rates also mimic the disparities in college graduation attainment among adult Coloradans,

with Hispanics having the lowest high school graduation rate and Asian-Americans having the highest. Other groups

that are consistently at risk of not graduating from high school include homeless children and children who are not

proficient in English. From 2006 through 2008, graduation rates have increased slightly for Black students but have

fallen for students with disabilities, those with limited English proficiency, homeless students, and those who are

economically disadvantaged.

Students who do not graduate from high school are the most likely to experience low incomes and face the health-

related consequences associated with lower incomes.

Economy

The downturn in the national economy since the end of 2007 has dramatically affected Colorado, resulting in the

state's worst downturn in 50 years. As of July, 2009, unemployment stood at 7.8 percent,

doubling since 2007

when the unemployment rate was at its lowest (3.8 percent). During the first half of 2009, there was a net loss of

over 74,000 jobs in Colorado, bringing the total number of jobs in the state to the same number there were in 2001.

Job losses have not been focused on one particular sector of the economy but have been broad-based. Only two

sectors showed some job growth in 2009: government and educational and health services. All other sectors of

the Colorado economy lost jobs. The Colorado Legislative Council suggests that the economy in Colorado will begin

to recover in 2010 but predicts a "snail-paced recovery."

Even with the increase in unemployment rates, Colorado and other western states have some of the lowest

unemployment rates in the country. Colorado was ranked 18th lowest among all 50 states; but all states bordering

Colorado have even lower unemployment rates. With the economy in a downturn, state revenues have also been

falling. Staff from the state legislature estimate that by fiscal year 2011-2012 the budget shortfall for the state will

reach \$838 million dollars, putting pressures on all state-funded health programs.

The National Center for Children in Poverty estimated that in 2007, 32 percent of Colorado's children lived in low-

income families whose income was less than 200 percent of the federal poverty level. Findings from the American

Community Survey estimate that 15.3 percent of children lived in families whose income was at or below 100

percent of federal poverty level during this same time period. It is important to note that the rate of children living in

low-income families is not evenly distributed throughout the population. Racial and ethnic minorities have much

higher rates of children who live in low-income families than the majority population (White, 19 percent; African

American/Black, 60 percent; and Hispanic/Latino, 56 percent). Rural (54 percent in 2006) and urban children (45

percent, 2007) are more likely to live in low-income families than suburban children (22 percent, 2007). The majority

of children living in low-income families live in families where the parents are married (60 percent) and have at least

one parent who has full-time year-round employment (65 percent) indicating that many of these families are having

trouble meeting expenses because they are working in low-wage jobs.

The above data on income were reported for periods prior to the economic downturn. The Bureau of Economic

Analysis found that personal income in Colorado declined by 1 percent in the 4th quarter of 2008 and another 0.7

percent in the first three months of 2009. Thus, it is important to remember that the data that are available on

income most likely underestimate the number of women and children living in poverty and in low-income families in

Colorado at this time.

Access to Health Care

Approximately 81 percent of Coloradans under the age of 65 have health insurance of some kind; over 86 percent of

those under 19 have health insurance. These percentages are low, however, compared to other states. Colorado

is ranked 36th among all states and the District of Columbia based on the percent of persons younger than 65 years

old who have health insurance coverage, 43rd for those under age 19, and 49th for those under age 19 and below

200 percent of the federal poverty guideline.

The highest rate of coverage is for White non-Hispanics with over 87 percent reporting that they have health

insurance. By contrast, less than half of all Hispanics younger than age of 65 with incomes below 200% of the

federal poverty designation have health insurance. It is unknown how many of those who are insured are

underinsured because deductibles and co-payments act as barriers to receiving care.

Several programs are available to reach low-income families and those without health insurance. Pregnant women

and children living in households at or below 205 percent of the federal poverty level are eligible for health

insurance coverage either through Child Health Plan Plus (CHP+) or Medicaid. Enrollments in these two programs

have increased, and 543,000 Colorado children are now covered. A total of 7 percent of all Colorado children were

enrolled in CHP+ at some time between July 2008 and June 2009, and 32 percent of all Colorado children were

enrolled in Medicaid in the same period. Other health care services available to low-income and uninsured persons

include 15 community health centers that operate 138 clinic sites in 35 counties. These are non-profit or public

health centers where 90 percent of their patients have incomes below 200 percent of the federal poverty level and

40 percent are uninsured by either public or private programs.

/2012/

The overall population for Colorado was 5,160,189 in 2010, and is projected to grow to 5,622,019 by 2015. Births in

2009 were lower than the number in 2008, with 68,605 recorded. Preliminary estimates for 2010 also suggest a

continuing decline to about 66,200 births. Deaths in 2009 totaled 31,132. Net migration was estimated at 48,200 in 2009.

In 2009, the Colorado high school graduation rate increased 0.7 percentage points to 74.6 percent. The Healthy

People 2020 objective is to increase high school completion with a regular diploma within 4 years after starting 9th

grade to 82.4 percent. Colorado's students continue to fall far short of this new target.

Colorado's economy continued to recover slowly. As of March 2011, Colorado's unemployment rate stood at 9.2

percent. For the same time period, Colorado ranked 33rd in the nation, a level of unemployment that was higher

than 32 other states plus the District of Columbia. Between January 2010 and January 2011, total

non-farm

employment increased by 13,100 jobs. The Colorado Legislative Council predicts slow job growth in 2011 along with

an elevated unemployment rate. The FY 2011-12 state budget shortfall is estimated to be about \$600 million

assuming the General Assembly maintains a 4 percent reserve. Budgets for MCH health-related programs will not be markedly changed.

Health insurance estimates for 2007 show that 82 percent of Coloradans under the age of 65 have health insurance

of some kind and over 87 percent of those under age 19 have health insurance. These percentages are low,

however, compared to other states. Colorado is ranked 35th among all states and the District of Columbia based on

the percentage of persons younger than 65 years who have health insurance coverage, 42nd for those under age

19, and 47th for those under age 19 and below 200 percent of the federal poverty guideline.

In May 2010, the eligibility level for Child Health Plan Plus (CHP+) increased from 205 to 250 percent of the federal

poverty level for pregnant women and children. Total enrollment of children in Medicaid and CHP+ is about 497,000,

up from the previous year (450,000). The new total is driven by an increase of about 10 percent in the number of

children enrolled in CHP+ and in the number of children enrolled in Medicaid. //2012//

/2013/

State Health Agency Priorities

In FY2011, CDPHE identified 10 key public health and environmental Winnable Battles where progress can be made

over the next three years. They are: clean air, clean water, infectious disease prevention, injury prevention, mental

health and substance abuse, obesity, oral health, safe food, tobacco and unintended pregnancy. The Winnable

Battles were chosen with consideration of national and local goals (CDC's Winnable Battles, the Seven Priorities for

EPA's Future and local public health and environmental priorities). The two Battles chosen as a focus this year for

the Prevention Services Division, which houses the MCH programs, are obesity and unintended pregnancy. While

many of the Winnable Battles overlap with the MCH priorities, obesity and unintended pregnancy are directly related

to Priority 1: Promote preconception health among women and men of reproductive age with a focus on intended

pregnancy and healthy weight and Priority 4: Prevent obesity among all children birth to 5.

Demographics

The total population of Colorado in 2012 is estimated at 5,196,200, a small increase from the previous year. Births

in 2010 were 66,346, a decline of more than 2,000 from the 2009 total. Preliminary estimates for 2011 suggest

another decline of at least 1,000 births from the 2010 level. The decline in births in recent years is thought to be

attributable to the negative impact of the economic recession on household income, as couples wait to start or

expand their families until their financial situations are more secure.

Deaths in 2010 were 31,435, and net migration was estimated at 38,100. Colorado is experiencing much slower

growth compared to the period of time before the 2008 recession. Virtually no change has occurred in the

distribution of the population by race/ethnicity reported in the full overview written two years ago, with about 70

percent of Coloradans identified as White/non-Hispanic, 20 percent as Hispanic, and 10 percent as other races.

Education

Colorado's education picture for high school graduation has not changed markedly since last year, although a small

improvement has been noted. According to the Colorado Department of Education, the graduation rate for the

state's class of 2011 was 73.9 percent, strictly measured as the percentage of all ninth-graders graduating who had

entered high school four years previously. The comparable figure for the class of 2010 was 72.4 percent. Since the

definition changed beginning in 2010, graduation rates before that year are not comparable. Differences between

major ethnic and racial groups are noticeable: the rate for White students was 81.1 percent; for black students,

64.6 percent; and for Hispanic students, 60.1 percent.

Economy

The state's economy has shown marked improvement since the report in last year's block grant. As of February

2012, the unemployment rate was 7.8 percent, a considerable drop from 9.2 percent in March 2011. Nonfarm payroll

jobs increased by 48,000 between February 2011 and February 2012, compared to 13,100 reported for the previous

year. The state's revenue picture has improved, and no new budget shortfall is predicted for FY 13; indeed,

revenues estimated in March 2012 exceeded December 2011 estimates by \$165 million. The overall increase is

mainly attributable to continued improvement in the job market and increased confidence among households and

businesses, according to the Colorado Department of Labor.

Health Insurance

Health insurance for Coloradans continues to be problematic. The Colorado Health Access Survey in 2011

determined that 829,000 Coloradans do not have health insurance, a statistically significant increase from the last

survey done two years previously. A total of 1.5 million people are also considered underinsured, so that more than

2.3 million people lack insurance or find what they do have is inadequate for their needs. One in six residents (16

percent) has no insurance and nearly two in six (29 percent) lack adequate insurance.

Total enrollment by children in Medicaid has increased from last year: over 429,000 received some service at some

point during FY 11, as did 110,000 children enrolled in the Child Health Plan. These figures reveal a six percent

increase over the combined total of 497,000 in the two programs in FY 10. //2013//

/2014/A map of Colorado counties is attached.

Demographics

The total state population in 2013 is estimated to be 5,267,800, an increase of 1.4 percent (71,600) from 2012. The

number of births for 2013 is anticipated to be 65,600, a slight increase from the recent low of 65,052 in 2011, which

had been the lowest level since 1999. While the declines in births in recent years have been attributed to the

economic recession beginning in 2008, a large drop of over 2,000 births between 2009 and 2012 among unmarried

mothers without a high school education and under the age of 25 may be attributed to the impact of the statewide

Colorado Family Planning Initiative which began in 2009 and heavily emphasized longacting reversible

contraceptives (LARC) for young women (see attached report). This investment in LARC led to an increase in use

among young women served by the Title X Family Planning Program. LARC use for youth ages 15-19 more than

doubled from 2,444 users in 2009 to 5,040 users in 2012. Substantial increases in LARC use were also noted among

postpartum teen mothers. In a recent report from the CDC, Colorado was highlighted for having more than 50

percent of teen mothers reporting using an IUD or implant post-partum. This was the highest proportion among all

the states surveyed. During the same time period, Colorado experienced a 34 percent decline in the teen fertility

rate and a 45 percent decline in the number of repeat (2nd order or higher) births to teens. Also, Colorado has one

of the lowest state rates of births to unmarried women: 23.9 percent in 2010, second only to Utah.

Deaths in 2012 are estimated at 32,600, about the same as in 2011 (32,566) and slightly higher than in 2010

(31,435). Net migration was 38,600 in 2012, a continued slow rate of growth. The distribution of the population by

race/ethnicity is little changed from recent years, with 70 percent of residents identified as White/non-Hispanic, 21

percent as Hispanic, and nine percent as other races.

Education

The high school graduation rate in Colorado reached 75.4 percent in 2012, an improvement of 1.5 percentage points

over the rate in 2011. Graduation rate increases were seen across nearly all racial and ethnic groups, and the rate

for minority students increased as fast as or faster than the rate for white students. Among racial and ethnic

groups, the on-time graduation rates for the 2011-2012 school year were 57.7 percent for American Indian

students; 82.9 percent for Asian students; 66.2 percent for black students; 62.5 percent for Hispanic students; 82.1

percent for white students; 70.1 percent for Native Hawaiian or Other Pacific Islander students; and 80.4 percent for

students who reported two or more races.

According to the American Community Survey for 2011, 89.7 percent of Colorado's population has at least a high

school education, and 36.3 percent has at least a bachelor's degree. Colorado ranks third among all 50 states

(behind Massachusetts and Maryland) in its percentage with at least a BA degree.

Economy

As of April 2013, the state unemployment rate was 6.9 percent, below the U.S. rate of 7.5 percent, and well below

the April 2012 state rate of 8.2 percent. The state rate in April 2013 was the lowest on record since January 2009.

The Colorado Department of Labor and Employment attributed the April unemployment rate to an expanding labor

force with more people finding work. The size of the labor force (2,362,700) is just 800 shy of the May 2008 peak

before the recession. Economists estimate that the state will add a total of 60,000 jobs in 2013 compared to 51,800 added in 2012.

State economic forecasts suggest that state revenues will grow \$548 million, or 7.1 percent, in the current 2012-13

budget year, more than double the amount that was projected in December 2012. Current spending through the

end of the state budget year is expected to be \$7.7 billion. Expected revenues for 2013-14 are anticipated to total

\$8.4 billion, an increase of \$700 million. State revenues are increasing because of improved economic growth.

Health Insurance

About 125,000 Colorado children, or 9.7 percent of all children, did not have health insurance in 2011. Although this

was a decrease from 132,000 uninsured children in 2010, the change was not statistically significant. About 89,000

of the uninsured children were eligible for a public health insurance program but were not enrolled. Of these

eligible but not enrolled children, about 39,000 were eligible for Medicaid and 50,000 were eligible for the Child Health Plan.

During state FY 12, nearly 485,000 children were enrolled in Medicaid at some point, and 126.000 were enrolled in

the Child Health Plan, for a combined total of 611,000. This total represents a 9.3 percent increase over the

combined total of 559,000 in the two programs the previous fiscal year.

The Colorado Health Benefits Exchange, the state program for increasing access to health insurance under the

Affordable Care Act starting in January 2014, is developing a website/marketplace that will go online in October

2013. Coloradans will be able to compare health insurance plans based on quality and price, and all plans will

include essential health benefits defined by the federal government. Plans will be subsidized by the federal

government on a sliding scale for individuals and families that cannot afford the cost. A public education campaign

was begun in the spring of 2013 to promote the marketplace, known as Connect for Health Colorado. Estimates

vary on the number of people who will obtain coverage in 2014, but it is likely that more than 466,000, a majority of

the uninsured, will qualify. //2014//

B. Agency Capacity

The following section describes the three primary units within the MCH Program that address pregnant

women, mothers, infants, children and youth, including children and youth with special needs. Information about

state support of communities, coordination with health components of community-based systems; and

coordination of health services with other services at the community level is provided by unit. Responses to the

questions about the CSHCN Unit's ability to provide and promote family-centered, community-based, coordinated

care including care coordination services for CSHCN and facilitate the development of community based systems

of services for such children and their families is integrated into the segment describing the CSHCN activities.

1. Services to pregnant women, mothers and infants

The Women's Health Unit (WHU) promotes health and wellness by promoting health and well-being, education

and support for women and men of reproductive age in Colorado. The unit administers programs that promote

lifestyles and behaviors that improve health status and emphasize the value of preconception health and family

planning as public health priorities. The WHU provides funding, oversight, direction, consultation, training and

technical assistance to state and local public and private entities serving women and families. The unit also

participates in program development and systems building efforts at the state and local levels and in analysis of

federal, state and local policies impacting these populations. The WHU administers the Prenatal Plus, Nurse

Home Visitor, Title X Family Planning Programs and the Colorado Family Planning Initiative. Under Maternal Child

Health (MCH), the WHU oversees the Healthy Baby Campaign.

The WHU administers the Prenatal Plus Program on behalf of the Colorado Department of Health Care Policy and

Financing (HCPF). Prenatal Plus is a Medicaid-funded program that provides care coordination, nutrition and

mental health counseling to eligible pregnant women who are at a higher risk for delivering low birthweight

infants. The program's multidisciplinary approach uses professionals to effectively address risk reduction for

women enrolled in the program. Care coordinators address client needs throughout pregnancy and up to 60

days postpartum. Concerns addressed include housing, nutrition, employment, domestic violence, substance

abuse, high life stress, and depression and/or other mental health problems that may increase

the risk of

delivering a low birthweight infant. The Prenatal Plus Program served approximately 1,900 women covering 21

counties through 34 sites comprised of local health agencies, community health centers, private non-profit

organizations, and hospital-based clinics. This program will be administered by HCPF as of June 2011, given that

administration of Medicaid benefits is the agency's primary mission. The MCH Program is focused on population-

based and infrastructure-building activities.

The Nurse Home Visitor Program funds the Nurse-Family Partnership (NFP) model, which is an evidence-based.

community health program that helps improve the lives of low-income mothers pregnant with their first child. An

NFP mother is partnered with a registered nurse early in her pregnancy and receives ongoing nurse home visits

(64 planned visits) that continue through her child's second birthday. Through ongoing home visits, mothers

receive the care and support they need to have a healthy pregnancy, provide responsible and competent care for

their children, and become more economically self-sufficient. The program disseminates nearly \$13 million in

master tobacco settlement funds annually to 19 local public health and non-profits agencies for nurse home

visitation services covering 53 of the states' 64 counties, approximately 2,590 mothers are served annually.

Nurse Home Visitor Program staff collaborate with HCPF to draw down federal Medicaid funding for Targeted Case

Management (TCM) services provided to first-time, low-income (up to 200 percent of the Federal Poverty Level)

mothers. The Nurse Home Visitor Program contributes the match for Medicaid reimbursements paid directly to the

providers. Medicaid reimbursements support program expansion by generating additional program revenue,

which is used to serve more families. Recent rate adjustments have resulted in a significant drop in

reimbursement for NHVP TCM.

Title X Family Planning distributes about \$4.7 million to 29 local public health and non-profit agencies in 38

counties to provide family planning services to about 62,000 men and women. Title X Family Planning staff work

closely with HCPF and the Centers for Medicare and Medicaid Services (CMS) in a long standing attempt to gain

approval for a Reproductive Health 1115 Medicaid Waiver for family planning services. The waiver is intended to

expand family planning services to men and women 19-50 years old with incomes up to 200 percent of the

Federal Poverty Level. As a result of the federal health care reform, states now have the option to create a family

planning-only benefit under a state plan amendment.

The Title X Family Planning, Colorado Family Planning Initiative and Nurse Home Visitor Program funding is

distributed among the network of local health departments, community health centers, hospitals

and non-profit

agencies to best support and build existing community infrastructure and to fund needed services in local

communities. The Prenatal Plus program is administered throughout the state in coordination with this same local

health network.

Per statute, the WHU staff cooperates with the University of Colorado Cord Blood Bank to transfer voluntary state

income tax check-off funds from CDPHE to the University for the Adult Stem Cells Cure Fund. The funds are used

to increase public awareness and to encourage umbilical cord blood donations to public blood banks to aid in the

cure of life-threatening diseases.

WHU personnel serves on a number of teams, including private organizations and other public agencies, related

to the unit's mission. These groups include the Adolescent Sexual Health Team, Advisory Council on Adolescent

Health, Colorado Clinical Guidelines Collaborative, Colorado Nurse-Family Partnership Coordination Team,

Perinatal Care Council, Folic Acid Task Force, Healthy Women/Healthy Babies, Infertility Prevention Project

Regional Advisory Committee, March of Dimes State Programs Committee, Tobacco Cessation Workgroup for

Pregnant Women and persons receiving Medicaid, Sexual Risk Prevention Group, Cessation Resource Alliance,

Covering Kids and Families Workgroup, Maternal Mortality Review Committee, Prevention First NARAL Education

Committee and the U.S. Department of Health and Human Services/ Office of Public Health and Science/ Women's

Health/ Region VIII Partners.

The WHU supports local communities in a variety of ways, including state, federal and private funding,

training and technical assistance. The MCH generalists and specialists work with 15 local county public health

agencies (LPHAs) on their MCH plans, which include preconception and prenatal goals. The MCH generalist within

the WHU provides consultation and assistance to LPHAs with their needs assessment and preparation of their

three-year MCH plans for all three core MCH populations.

The Healthy Baby Campaign provides support and resources to local communities related to low birth weight and

inadequate weight gain through technical assistance, the campaign website and continued dissemination of

campaign materials, including brochures, weight grids and BMI wheels.

The Colorado Family Planning Initiative, funded by an anonymous donor, distributes \$4.8 million to 29 local public

health and non-profit agencies in 38 counties to help expand family planning services to men and women.

MCH staff worked with the Colorado Clinical Guidelines Collaborative and the HealthyWomen HealthyBabies

Preconception Care Workgroup to develop a Preconception and Interconception Clinical Care Guideline. The

guideline was completed in December 2009 and disseminated to nearly 4,500 health care providers around the state.

A Tobacco Cessation Workgroup for Pregnant Women and persons receiving Medicaid were developed with the

State Tobacco Education and Prevention Partnership to address the high rates of tobacco use among these

populations. The group's goal is to increase use of the Colorado QuitLine service and Medicaid's tobacco

cessation benefit. The staff also worked with the QuitLine to enhance the protocol to more effectively target

pregnant and postpartum women.

WHU personnel also participates in a number of groups related to community-based health systems, including

Medical Policy Advisory Committee, Policy Advisory Committee and the Medicaid Waiver Advisory Committee for the

Title X Family Planning program, Prenatal Plus Advisory Committee and the MCH Coordinating Team.

2. Preventive and Primary Care Services for Children

The Child, Adolescent, and School Health (CASH) Unit leads efforts to improve the health and well-being of all

Colorado children and adolescents through health promotion, public health prevention programs and access to

health care. The unit provides leadership in setting priorities; identifying and promoting best practices to address

the priorities; and working with LPHAs, early childhood councils, schools and other state and community partners

to develop and implement comprehensive, coordinated strategies to improve the health of children and

adolescents.

The organizational structure of the unit includes three teams: an early childhood team; an adolescent and school

health team; and the Tony Grampsas Youth Services team. Across these teams, a variety of state- and

federally-funded programs and initiatives to address the needs of children, youth and families are administered.

The Early Childhood Team is currently focused on the following programs/initiatives: the Early Childhood

Comprehensive Systems Grant, the Early Childhood Health Integration Initiative, the Assuring Better Child Health

and Development Project, and the Early Childhood Obesity Prevention Needs Assessment Project.

The Early Childhood Systems (ECCS) Grant supports a statewide alliance of early childhood partnerships working

together to create a comprehensive system for young children birth to age eight and their families. The Early

Childhood Colorado Framework and the Framework in Action State Plan were developed to guide the state's

systems-building efforts. Colorado's Lieutenant Governor identified early childhood issues as a top priority

and the ECCS Director, a CDPHE employee, is now physically located within the Office of the Lieutenant Governor.

The CASH Unit receives funding from a local foundation to provide technical assistance to those local early

childhood councils receiving Early Childhood Health Integration grants. The technical assistance supports the

integration of health into local early childhood systems-building efforts. A staff person was hired to assist the local

councils in the development and implementation of local health integration plans.

The CASH and Health Care Program for Children with Special Health Care Needs (HCP) Units work together to

implement the Assuring Better Child Health and Development Project (ABCD) that focuses on: promoting the use

of standardized developmental screening tools in primary health care settings to help increase early identification

of developmental concerns; and strengthening the referral and service-delivery processes for early intervention.

In partnership with the Nutrition Services Branch (WIC and CACFP) and the Colorado Physical Activity and

Nutrition Program, the CASH Unit coordinated an early childhood obesity prevention needs assessment

project. The results of the needs assessment will be used to inform a statewide strategic plan to address early

childhood obesity, with a focus on prenatal through age two.

The Adolescent and School Health Team within the Unit, is focused on the School-Based Health Center (SBHC)

Program, the Coordinated School Health Program, school health technical assistance, and youth sexual health

initiatives.

The SBHC Program, in collaboration with the Colorado Association for School-Based Health Care, convenes,

facilitates, and provides technical assistance to schools and provider agencies that develop, implements, and

supports approximately forty SBHCs throughout the state. The SBHC Program, located within the CASH Unit,

receives one million dollars in state general fund dollars to support SBHCs throughout Colorado. In addition,

HCPF, in collaboration with CDPHE, has received a five-year evaluation grant for SBHCs in Colorado funded

through the Child Health Insurance Program Reauthorization Act. In order to meet the grant deliverables, the

CASH Unit will be hiring one additional full-time staff person. Colorado is in the second year of a five-year funding

cycle for the Coordinated School Health Program from the Centers for Disease Control and Prevention. The

funding supports a partnership between the Colorado Department of Education and CDPHE to build state and

local infrastructure to support the coordinated school health model, with an emphasis on nutrition, physical

activity and tobacco prevention. In addition to CDC funding, the Coordinated School Health Program receives

funding from a local foundation to support school health teams throughout Colorado to address the program's

priorities.

One of the three MCH Generalist Consultants is located within the CASH Unit, and has expertise in school nursing.

As part of this role, the consultant collaborates with the Colorado Department of Education's statewide nurse

consultant to prove technical assistance and training for school nurses.

The CASH Unit is providing leadership for a collaborative effort to address youth sexual health. The Unit is

partnering with the Women's Health Unit, the STI/HIV Program, Colorado Youth Matter (formerly, the Colorado

Organization on Adolescent Parenting, Pregnancy, and Prevention), Pregnancy, and Prevention, and the

Department of Education to create a statewide youth sexual health strategic plan.

The third team within the CASH Unit implements is the Tony Grampsas Youth Services Program is focused on the

prevention of youth crime and violence, as well as reducing child abuse and neglect. The Tony Grampsas Youth

Services Program, funded with master settlement tobacco funds, supports over 90 contracts with local non-profit

organizations throughout the state to prevent youth crime and violence, as well as child abuse and neglect.

These funds support early childhood programs, student drop-out prevention programs, youth mentoring,

restorative justice, after-school programs, as well as a variety of other programs targeting high-risk youth and

families.

Advisory groups convened by the CASH Unit include the Early Childhood Partners, the Interagency School Health

Team, the Advisory Council on Adolescent Health, the Colorado Youth Development Team, the Youth Partnership

for Health and the Tony Grampsas Youth Services Board. The Early Childhood Partners is a multi-disciplinary group

of public and private early childhood stakeholders who advised in the creation, and now implementation, of the

Early Childhood Colorado Framework in Action State Plan. The Interagency School Health Team serves as the

advisory group for the Coordinated School Health Program. The Advisory Council on Adolescent Health is an

interdisciplinary group of adolescent health experts and community advocates, who advise the Colorado

Department of Public Health and Environment, educate and inform the public, and advocate for policies and

programs to improve the health and well-being of all Colorado adolescents. The Colorado Youth Development

Team is a public-private partnership of youth and professionals that raises awareness, promotes, enhances and

unites positive youth development efforts and strategies across the State of Colorado. The Youth Partnership for

Health is composed of 25 diverse youth, recruited from all parts of the state. YPH advises the state health

department on policies and programs that affect adolescents. The Tony Grampsas Youth Services Board is an 11-

member that provides guidance and oversight for the TGYS Program. Appointments to the board are made by the

Governor, the Speaker of the House of Representatives, the Senate President, and the Senate Minority Leader.

Collectively, these advisory groups include representatives from the Department of Human Services (Divisions of

Behavioral Health Services, Child Care, Youth Services, Child Welfare, and the Office of Homeless Youth); the

Department of Transportation; the Department of Education (Coordinated School Health Program, School Nursing

Services, Special Education Services, Early Childhood Initiatives); the Department of Public Safety: the Colorado

State University Cooperative Extension Program; higher education; Colorado-based foundations and other many

other public and private partners.

3. Services for Children with Special Health Care Needs (CSHCN)

The Children with Special Health Care Needs Unit includes the Health Care Program for Children with Special

Needs (HCP), the Newborn Screening Programs, the Family Leadership Initiative and The Colorado Medical Home Initiative (CMHI).

The unit's purpose is to build a sustainable system of care for CSHCN and their families in alignment with the six

CSHCN national outcome measures. To champion a medical home approach for families, the HCP Program has

chosen two core strategies; these are care coordination and local systems building. It is expected that successful

implementation of these strategies will decrease systems barriers to care and reduce unmet needs among

families.

All programs/initiatives in the CSHCN Unit collaborate with other state agencies and private organizations for

children with special health care needs.

A statewide clinic system exists for children with special health care needs resulting from the coordination of local

and state resources. The HCP program provides gap filling care coordination services and strives to avoid

duplication and to compliment other similar services in the state. The HCP state program contracts with 15

counties to serve as regional offices to provide administration and implementation of the program statewide.

Program planning and reporting processes are implemented with state staff support and consultation. HCP-

sponsored clinic programs provide access to specialty medical care, genetic, and diagnostic and evaluation

services. These clinics are important in ensuring that families have access to specialized pediatric health services

in rural and frontier areas of the state.

HCP has developed a care coordination definition describing three levels of coordination, service standards and

an evaluation process. The care coordination definition and standards are used with Medicaid EPSDT outreach.

Early Intervention Colorado, children receiving clinic services, the Colorado Responds to Children with Special

Needs birth defects registry, and for infant hearing screening follow-up.

Public health nurses and HCP's regional office teams work together so that there is coordination at the local level

among the services needed by families and children. All local HCP agencies provide resource and referral

information. Each HCP agency provides care coordination services to targeted populations depending on

community need, capacity, and reimbursement. Additionally, local systems building services are provided in every

county. Most local HCP staff are also involved in other interagency work such as serving on child protection teams.

working with school districts to support parents in special education staffing, and developing Individual Education

Plans or Individual Family Service Plans.

HCP also provides access to specialty services and coordination of primary and specialty care by providing clinics

in outlying and rural communities. Last year there were 2,428 community encounters by public health contractors

with other providers, agencies and organizations to organize services for ease of use by families. Access to

specialty medical providers was addressed through 99 Specialty Clinics (Orthopedic 8, Neurology 64, Cardiology 5,

Rehabilitation 18, and Pediatric 4). There were 1,116 total completed patient visits offered through 14 specialty

clinic sites in 13 counties.

Through the state health department's laboratory, the Newborn Screening Program provides screening at birth

and again at eight to 14 days of age for a variety of metabolic and genetic diseases for all infants born in the

state. The program provides data to ensure appropriate follow-up with contract sites. The Newborn Hearing

Screening Program connects hospital birth certificate clerks and hospital audiologists with local HCP and early

intervention personnel to ensure follow-up screening and referral into early intervention. The metabolic screening

program connects families with The Children's Hospital and community-based services. The program contracts

with The Children's Hospital for follow-up services and makes connections to community supports to develop a

medical home approach for children with metabolic conditions.

The Colorado Infant Hearing Program tests the hearing of infants at birth to identify deaf and hearing impaired

infants and makes appropriate referrals. The Newborn Hearing Screening Program provides support to local

communities that have low follow-up rates, by developing Early Hearing Detection and Intervention (EHDI) teams

to develop systems for follow-up and referral into early intervention. The Colorado Infant Hearing and Newborn

Screening Advisories address standard practices, funding, and program development. The committee is

comprised of parents, consumers, public health professionals, physicians, and other stakeholder state agencies.

The Colorado Infant Hearing Program has a CDC Early Hearing Detection and Intervention (EHDI) grant that is

used to integrate several data systems: the newborn hearing; newborn metabolic screening; the Colorado

Responds to Children with Special Needs birth defects registry data, metabolic clinics at The Children's Hospital,

and the Traumatic Brain Injury Program.

Colorado Responds to Children with Special Needs (CRCSN) is the state's birth defects monitoring and prevention

program. CRCSN and HCP share data so that HCP can link children and families, who have been identified with

birth defects and related disabilities, with early intervention services and potentially care coordination.

The CSHCN Unit's Family Leadership Initiative partners with the Department of Education and the Department of

Human Services, early childhood efforts, the state Prevention Leadership Council of six state departments, as well

as non-profit organizations to advise the development of family engagement and leadership in the state. These

partners promote the importance of family engagement and leadership and help to identify funding sources for

local implementation of the Family Leadership Training Institute. The CSHCN Unit Family Leadership Initiative

supports communities to implement the Family Leadership Training Institute (FLTI), an eleven week course to

teach civic leadership and to support community projects for families and children.

The Colorado Medical Home Initiative (CMHI) is a state systems building initiative to improve the quality of the

pediatric health care system to ensure a comprehensive, coordinated medical home team approach for all families.

The CMHI partners with the Medicaid agency to implement Colorado's Medical Home legislation and to build the

infrastructure to support a medical home system. The initiative partners with a broad array of stakeholders to

build a system to support a medical home approach for all children. The Department of Health Care Policy and

Financing, the Medicaid and SCHIP agency, partners with the CMHI to provide the clinical practice and quality

improvement to ensure a medical home approach. The CMHI convenes partners to address state systems

development, including the role of public health and families/consumers.

The CMHI Advisory Board provides updates and networking for over 50 agencies, organizations and individuals on

a bi-monthly basis. The CMHI also provides information about the state's medical home efforts that connect and

build infrastructure for an improved system. CMHI provides tools such as a medical home website and collects

information about local projects.

The Integrated Services for Children with Special Health Care Needs implementation grant supports a project that

is taking action to overcoming local systems barriers to a medical home approach in four counties (Boulder,

Summit, Larimer and Mesa).

The Colorado Department of Human Services contracts with the HCP Program to provide care coordination

through local offices to families of children with traumatic brain injury. Local HCP staff work closely with early

intervention coordinators to assure that health-related early intervention services are coordinated.

The HCP program also works closely with Early Intervention Colorado at the Department of Human Services,

Division of Developmental Disabilities to implement HCP care coordination standards, and to define respective

roles in serving infants and toddlers with special health care needs at the community level. An HCP staff member

represents the program and the department on the Interagency Coordinating Council and the state level

Memorandum of Understanding committee.

In Colorado, blind and disabled individuals under the age of 16 receive rehabilitation services under Title XVI

(SSI). All SSI beneficiaries under 16 years of age are automatically eligible for Medicaid. Community-based EPSDT

outreach workers call all newly enrolled SSI beneficiaries to assess whether each child's medical and support

needs are being met. In the majority of cases, Medicaid is covering all of the medical needs. HCP personnel at the

local community level provide care coordination when families have more complex medical or psychosocial needs.

Other Programs Supported by MCH funds

Child and maternal mortality reviews are done by a multi-disciplinary team working together to determine the

underlying causes of maternal and child deaths. The reviews also promote preventive programs that may help

reduce premature death. Multiple agencies and department programs are involved in both reviews.

The Family Healthline is the statewide MCH information and referral service. The Healthline resource specialist

assists women, families, and individuals in locating free or low-cost health care services. Information is provided

about other programs such as emergency shelters, food subsidies, or mental health. The Healthline specialists

speak fluent Spanish and English.

Culturally competent care is provided to the State's MCH populations. The state health

department has an Office

of Health Disparities and a Citizen's Commission on Minority health. The office is dedicated to eliminating racial

and ethnic health disparities in Colorado by fostering systems change and capacity building through multi-sector

collaboration, so that all Coloradans will have equal opportunity to be healthy, regardless of race and ethnicity.

The Minority Health Advisory Commission was created in 2005 and established in statute in 2007. The commission

provides a formal mechanism for community members to provide input on health programming at the level of the

Colorado Department of Public Health and Environment Executive Director. It also helps the department

determine culturally innovative data collection strategies and strengthens collaborations between the Colorado

Department of Public Health and Environment and communities of color.

The Prevention Services Division, where the MCH Program is housed, has developed a Cultural Competence Plan

based upon a division-wide assessment. Additionally, all staff received training this year on the Social

Determinants of Health and will receive additional training on cultural competence in the coming year. All division

personnel are required to participate in cultural competency training as part of their annual performance plan and

all divisions units will implement activities that support the plan.

In 2009, the Child, Adolescent and School Health Unit coordinated a learning circle series, entitled, the

Dimensions of Diversity. Part I included an overview of the social determinants of health framework, and a

presentation of data that demonstrates how health disparities are a result of the social determinants of health.

Part II focused on strategies for working in multi-cultural settings and was facilitated by the CDPHE Office of

Health Disparities. The unit is continuing to participate in monthly learning circles. In December 2010, the unit will

create a photo essay project that captures observations and insights.

Staff from both the CASH and Women's Health Units also viewed and discussed the Unnatural Causes six-

segment documentary, produced by PBS, which illuminates the root causes of the socio-economic and racial

inequities in health.

In 2009, the Women's Health Unit created the Health Equity Learning Community. The goal of this learning

community is to address health equity and disparities through staff learning and practical application of data,

information and experiences. The learning community objectives are all related to improving staffs knowledge of

health disparities, health equity and cultural competency. In December 2010, the unit will create a photo essay

project that captures community-based observations and insights related to the social determinants of health.

The CSHCN Unit held a conference about cultural competency in October 2008 that featured Wendy Jones from

the National Center for Cultural Competence with follow-up meeting scheduled in 2009.

Data collected, analyzed and used through the MCH program is available by gender, race and ethnicity so

information about culture does inform program development and service delivery.

/2012/1. Services to pregnant women, mothers and infants

In 2010, the Women's Health Unit changed the name of the Prenatal Program to Maternal Wellness given that

the work of the team encompasses the health of women and their families from preconception and pregnancy

through postpartum and into early childhood.

Administration of the Medicaid-funded Prenatal Plus Program was transferred to the Department of Health Care

Policy and Financing (HCPF) effective July 1, 2011, where it will continue as a Medicaid benefit under the direction

of the state Medicaid agency. In 2010, the Prenatal Plus Program served approximately 2,000 women in 21

counties.

WHU completed the final application process for \$1,842,294 for a 27-month grant period to provide evidence-

based home visiting programs for children and families in at-risk communities. Funding is expected to be

distributed to local providers in Colorado by September 2011.

The Title X Family Planning Program, served 68,175 clients in 2010, a 12.2 percent increase. The number of Title X

clients using a LARC method (intrauterine devices or contraceptive implants) rose by 48 percent compared to

2009, for a total of 8,005 LARC users.

2 & 3. Preventive and Primary Care Services for Children and Services for Children with Special Health Care Needs

Upon the retirement of the Children with Special Health Care Needs (CSHCN) Unit Director, a new Children and

Youth Branch was formed in April 2011, integrating the CSHCN and the Child, Adolescent and School Health

(CASH) Units. The branch is directed by Rachel Hutson, who previously served as the Director of the CASH Unit.

The mission of the Children and Youth Branch is to: "Maximize the health and well-being of all Colorado children,

youth and families by partnering with communities." The integrated focus and new organizational structure

provide more opportunities to enhance population-based efforts on behalf of all children and youth, including

those with special health care needs.

As of June 2011, the Early Childhood Systems (ECCS) Director position will be transferred to the Lt. Governor's

Office and CDPHE will contract with the Office for the ECCS grant deliverables.

The Children and Youth Branch continues to receive funding from a local foundation to provide

technical

assistance to local early childhood councils to promote the integration of health into local early childhood systems-

building efforts. These local health integration efforts align with several of the state's MCH priorities, most

specifically those related to improved developmental screening and referral rates; prevention of dental caries in

all children birth to five; and reducing barriers to a medical home approach.

The Early Childhood Team also supports the Assuring Better Child Health and Development Project (ABCD) that

focuses on: promoting the use of standardized developmental screening tools in primary health care settings to

help increase early identification of developmental concern; and strengthen the referral and service-delivery

processes for early intervention.

In partnership with the Nutrition Services Branch (WIC and the Child and Adult Care Food Program) and the

Healthy Living Branch, members of the branch's Early Childhood Team coordinated an early childhood obesity

prevention needs assessment project. The results of the needs assessment were presented to 40 key

stakeholders who provided input to inform a CDPHE action plan to address early childhood obesity, with a focus

on prenatal through age two.

The Local Implementation Team includes branch staff who works specifically with local public health agencies to

implement the MCH contract components for the Health Care Program (HCP) for Children with Special Needs. The

program's purpose is to build a sustainable system of care for CSHCN and their families in alignment with the six

CSHCN national outcome measures. To champion a medical home approach for families, the HCP Program has

chosen three core strategies: care coordination, specialty clinics and local systems building.

Colorado Responds to Children with Special Needs (CRCSN) is the state's birth defects monitoring and prevention

program. CRCSN and HCP share data so that HCP can link children and families, who have been identified with

birth defects and related disabilities, with early intervention services and potentially care coordination. CRCSN

and HCP are exploring a partnership with Family Voices to assist with the CRCSN follow-up through a

pilot project with one of the local HCP programs.

CDPHE returned administration of the traumatic brain injury (TBI) program to The Colorado Department of Human

Services (CDHS) as of June 30, 2011. Children and youth with TBI will continue to be served with HCP care

coordination as needed.

With the development of the new branch, the Tony Grampass Youth Services Program, which is focused on the

reduction of youth crime and violence, was moved to the Injury, Suicide and Violence Prevention

(ISVP) Unit.

Within the past year, representatives from the Advisory Council on Adolescent Health and the Colorado Youth

Development Team, developed a plan to integrate the two teams into one larger statewide public-private

partnership that focuses on improving the health and well-being of Colorado youth. The purpose of the new

group will be to finalize a common youth framework for professionals across the state; develop and implement

strategies to improve youth health and well-being; build and enhance partnerships at the state and local levels;

and provide networking and professional development opportunities for members.

Also in the past year, 180 employees from the Prevention Services Division participated in a six part cultural

comptency training for a total of 18 hours per person.//2012/

/2013/

The Women's Health Unit is now the Women's Health Branch (WHB). The WHB administers the Title X Family

Planning Program, Colorado Family Planning Initiative, Nurse Home Visitor Program (NHVP) and Maternal, Infant

and Early Childhood Home Visitation (MIECHV)]. The state's Breast and Cervical Cancer Screening program,

Women's Wellness Connection, was transferred to the WHB in November of 2011 in order to house all Division

direct service delivery programs within one Branch. The WHB is also responsible for two MCH priorities:

preconception health and pregnancy-related depression.

The MIECHV program funds the following evidence-based home visitation models: NFP, Parents as Teachers

(PAT), Home Instruction for Parents of Preschool Youngsters (HIPPY), Healthy Steps and the Early Head Start

Home-Based Program. Initial MIECHV funding is allocated to the state's five highest risk communities based on a

set of risk assessment criteria set forth in the grant application.

In 2011, the WHB received \$12.7 million in NHVP funds to provide the NFP model to 2,500 mothers. Under

MIECHV, the branch also received \$1.8 million in Year 1 formula funding, \$2.3 million in Year 2 formula funding and

\$3.7 million in Year 1 competitive funding for local planning and implementation of evidence-based home visitation programs.

The Title X Family Planning Program served 64,938 clients in 2011. The number of Title X clients using a LARC

method (intrauterine devices or contraceptive implants) increased in 2011 to 9,257 users. For feasibility reasons

and with the advent of health care reform, HCPF rescinded the Reproductive Health 1115 Medicaid Waiver

application for family planning in December 2011 in anticipation of greater health care coverage for the nation,

including reproductive health services.

The Tobacco Cessation Workgroup for Pregnant Women and Persons Receiving Medicaid completed its work to

increase use of the Quitline and disbanded.

The MCH Team formed in October 2011 and moved into the CYB in April 2012. The MCH Program Manager

supervises the three MCH Generalist Consultants who support local public health agencies and the MITs, as well

as the MCH Program Specialist who prepares Colorado's Block Grant application and SSDI. This structural move

further supports the integration of the MCH and HCP local implementation efforts, in addition to fostering

connections with the population-based efforts of the Early Childhood Unit and the Youth and Young Adult Units

that were already housed within the branch. In addition, the Interagency Prevention Systems Initiative moved

into the CYB. The initiative was created through legislation in 2000 and is charged with aligning state agency

prevention efforts that target children and youth.

In November 2011, the Health Care Program for Children with Special Needs (HCP) launched a new care

coordination model and CYSHCN data system. The care coordination model includes five core components: an

intake interview; assessment of need; development of an action plan; a six-month review of action plan

progress; and case closure. This standardized framework, and associated data collection process, is enabling the

HCP program to collect more consistent and accurate data that reflects the volume and type of service provided

by HCP care coordinators. HCP still supports specialty clinic services and standardized the approach for

clinic delivery within a regional system.

Cultural competency training and translation/interpretation services for state staff continue in accordance with

the division's cultural competency strategic plan. //2013//

/2014/ For the past several years, CDPHE prioritized health equity as a cross-cutting strategic priority. To this

end, the Health Equity and Environmental Justice (HE/EJ) Collaborative formed with representation from

every Division. The HE/EJ Collaborative focuses on populations who experience disproportionate disease, illness

and environmental burden such as racial and ethnic minorities; lesbian, gay, bisexual and transgender persons:

persons experiencing disabilities; place of residence; and socio-economic status.

The Collaborative developed a vision, mission, and strategic plan. The strategic goals of the collaborative include

data, workforce development, meaningful community involvement, resource alignment, policy development and communication.

Workgroups formed for each strategic goal area. The work groups are developing action

plans for the goal area,

and assuring implementation and completion of the action plan. The MCH Unit Manager and a MCH Generalist

Consultant are participating on the resource alignment and meaningful community involvement work groups, respectively.

The MCH Unit Manager also initiated an exploratory research project to identify evidencebased strategies for

addressing the upstream causes of health inequities, or the social determinants of health (SDOH). Public health

and MCH research demonstrate a strong link between MCH population health outcomes and the SDOH such as

income, education, housing, child care, racism, and social support. Despite this relationship, state and local

health departments and MCH programs struggle to address these factors in an effective way.

The Colorado program is in the initial stages of applying Brownson's Evidence-based Public Health Framework to

identifying evidence-based strategies that the state MCH program might implement to more effectively address

the SDOH and as a result, impact those long-standing and complex MCH health issues that challenged MCH as a field in years past.

Application of the public health framework includes conducting a community assessment to assess what

stakeholders are doing to address the SDOH. Key informant interviews with key stakeholders

working in other Colorado sectors and within CDPHE are being conducted. A survey of state MCH staff was

conducted to learn what is already happening within Colorado's program and what team members think the state

MCH public health role should be. This survey may also be administered with local public health agencies.

In fall of 2013, once the community assessment is complete, a literature review of evidence-based strategies will

be conducted to address the SDOH (with a focus on health outcomes). Findings will be summarized.

Recommendations will be developed and shared with the MCH Steering Team who will use this information to

inform future needs assessment and planning efforts.

In the past, Early Childhood Comprehensive Systems (ECCS) grants helped Colorado build integrated early

childhood service systems that focus on systems building across multiple sectors to better meet the needs of children and families.

The Funding Opportunity Announcement (FOA) recently posted for a new 3-year project period for the ECCS grant

opened the applicant pool to any governmental agency or non-profit agency. In Colorado, the state systems

team is called the Early Childhood Colorado Partnership (ECCP). In 2012, ECCP

designated Civic Canopy, a local

organization that works with residents to affect change in neighborhoods and communities, and individuals to

affect change in organizations and institutions, as the applicant for the new ECCS grant. As the grantee, Civic

Canopy will serve as the backbone organization to lead the collective impact of the Early Childhood Colorado

Partnership. //2014//

C. Organizational Structure

The Colorado Department of Public Health and Environment is one of sixteen Colorado state agencies that are all

located in Denver. Martha Rudolph is the Executive Director, and reports to Governor Bill W. Ritter, Jr. A CDPHE

organization chart is posted at http://10.1.0.61/ic/orgchart.pdf.

The MCH program is located within the Prevention Services Division (PSD) which has two centers: the Center for

Healthy Families and Communities and the Center for Healthy Living and Chronic Disease Prevention, along with an

Office of Policy, Fiscal Analysis and Operations. A cross-divisional Epidemiology, Planning and Evaluation Unit was

developed about three years ago which provides all of the epidemiology and evaluation services for all programs

within the PSD, including MCH. Jillian Jacobellis, PhD directs the division.

The Center for Healthy Families and Communities houses all MCH activities and is directed by Karen Trierweiler, MS,

CNM who is also the state MCH Director. The Center for Healthy Families and Communities includes the Special

Supplemental Nutrition Program for Women, Infants and Children (WIC); the Child and Adult Care Food Program

housed with WIC; the Women's Health Unit (Family Planning, Prenatal, Prenatal Plus and Nurse Home Visitor

Programs); the Child, Adolescent & School Health Unit (Early Childhood Initiatives, Adolescent Health Program,

School-Based Health Centers, Coordinated School Health Program and the Tony Grampsas Youth Services Program);

the Children with Special Health Care Needs Unit; the Injury, Suicide and Violence Prevention Unit; and the Center's

Fiscal and Administrative Services Unit.

The Center for Healthy Living and Chronic Disease Prevention includes the Chronic Disease Prevention Branch

(Diabetes; Cardiovascular Disease; Comprehensive Cancer Program; Breast & Cervical Cancer Program; and the

Oral Health Unit; the Healthy Living Branch that includes the Healthy Aging Unit, State Tobacco Education and

Prevention Partnership, Colorado Obesity, Physical Activity and Nutrition Unit; and a Center-specific Fiscal and

Administrative Services Unit. The Center has recently been reorganized according to function as opposed to

program.

The Office of Policy, Fiscal Analysis and Operations includes the Interagency Prevention

Systems for Children and

Youth, which contains the Inter-Departmental Prevention Leadership Council; the Primary Care Office; and provides

coordination of the Division's overall fiscal policy and human resources functions.

The Epidemiology, Planning, and Evaluation (EPE) Branch works collaboratively with programs in the Prevention

Services Division and other partners to conduct systematic collection, analysis and interpretation of population-

based and program specific health and related data in order to assess the distribution and determinants of the

health status and needs of the population, for the purpose of planning and implementing effective interventions.

promoting policy development, and evaluating the outcome of these activities.

MCH funds are distributed to local contractors (primarily local health agencies) via a formal planning process. Based

on the state-defined MCH priorities, contractors are asked to assess and prioritize the local health status needs of

the prenatal, child and adolescent, and children with special health care needs populations and to identify how their

allocated MCH funds will be used. The services or activities they implement are expected to address the Colorado

MCH priority areas. The state-level MCH program assists agencies by providing consultation and technical

assistance in developing and carrying out plans and managing statewide initiatives and efforts. More information

about the MCH planning process and forms are at www.mchcolorado.org.

/2012/ Dr. Christoper Urbina, MD, MPH is the new Executive Director of the CDPHE, reporting directly to Governor

John Hickenlooper. A CDPHE organization chart is posted at http://www.cdphe.state.co.us/ic/orgchart.pdf.

Chris Lindley, MPH, PhD(c) now directs the PSD.

The Center for Healthy Families and Communities now includes the Special Supplemental Nutrition Program for

Women, Infants and Children (WIC); the Child and Adult Care Food Program housed within WIC; the Women's

Health Unit (Title X Family Planning, Colorado Family Planning Initiative, Maternal Wellness, Home Visitation

Programs, Healthy Baby Campaign and Adult Stem Cells Cure Fund); the Children and Youth Branch (Early Childhood

Initiatives, Adolescent Health Program, School-Based Health Centers, Coordinated School Health Program and

Children with Special Health Care Needs); the Injury, Suicide and Violence Prevention Unit (includes the Tony

Grampsas Youth Services Program); and the Center's Fiscal and Administrative Services Unit. An organizational

chart for the center is attached.

After re-organization, The Center for Healthy Living and Chronic Disease Prevention now includes the Chronic

Disease Prevention Branch (Self Management Services Unit, Oral Health Unit, Screening Services Unit and Health

Systems Change Unit); the Healthy Living Branch (Policy Development Unit, Policy Implementation Unit, and Healthy

Communities Unit); the Healthy Equity, Communications and Planning Branch (Health Communications Unit and

Health Equity Unit) and a Center-specific Fiscal and Administrative Services Unit.

The Maternal, Infant and Early Childhood Home Visiting (MIECHV) program fits in closely with the overall MCH

program at CDPHE. Several outcome measures established for the MIECHV program directly relate to MCH priorities,

including the promotion of preconception health; screening and referral for pregnancy related depression; and

developmental and social-emotional screening and referral of children birth to 5. Other outcome measures reflect an

intention to impact the overall health of children, including oral health, and to improve collaboration between

systems and with families. //2012//

/2013/ The former Center structure was dismantled in August 2011. The Title V MCH Director now also serves as the

Section Chief for Programs and Services and Deputy Division Director for the Prevention Services Division.

Programming under the purview of the Title V Director include the Special Supplemental Nutrition Program for

Women, Infants and Children (WIC); the Child and Adult Care Food Program housed within WIC; the Women's

Health Branch (Family Planning, Maternal Wellness, Home Visitation Programs, Healthy Baby Campaign, Adult Stem

Cells Cure Fund and Women's Wellness Connection); the Children and Youth Branch (Early Childhood Initiatives,

Adolescent Health Program, School-Based Health Centers, Coordinated School Health Program and Children with

Special Health Care Needs); the Injury, Suicide and Violence Prevention Branch (includes the Tony Grampsas Youth

Services Program); the Healthy Living and Chronic Disease Prevention Branch; and the Health Equity and Access

Branches, which includes Oral Health. An organizational chart for the division is attached. The latest division re-

organization has established separate Branches for Prevention Health Policy, Systems and Analytics, Health

Communications and Fiscal and Administrative Operations, which includes the Epidemiology, Planning and Evaluation

Branch.

Legislation was crafted during the FY13 session to establish an Office of Early Childhood within the Colorado

Department of Human Services (DHS). The following programs would have been transferred to the new office:

Colorado Children's Trust Fund and Family Resource Center programs, the Tony Grampsas Youth Services Program

and both the federal MIECHV and state nurse home visitor programs. The legislation did not pass, and the DHS

plans to establish a similar office, aggregating internal human service programs related to early childhood. The

programs mentioned earlier will continue to be housed at CDPHE. //2013//

/2014/ In June 2013, Dr. Christoper Urbina left his position as Executive Director of CDPHE and Karin McGowan was appointed Interim Director.

Chris Lindley is no longer the PSD Director. Karen Trierweiler is serving as Interim Director.

The Children and Youth Branch and the Women's Health Branch were re-organized. The new Children, Youth and

Family Branch houses programs with a population-based and infrastructure-building focus (The MCH Unit, The Health

Care Program for Children and Youth with Special Needs (HCP) Unit, and the Population and Community Health Unit

which includes Maternal Wellness, Early Childhood Initiatives, and Youth Health) (see attached chart). The Women's

Health Branch is now the Health Services and Connections Branch which houses programs providing direct and

enabling services (Family Planning, Women's Wellness Connection, and School-Based Health Centers).

The new Office of Performance Improvement (OPI) supports CDPHE through four core efforts:

1. Strategic Planning/Deployment -- OPI's role in strategic planning is to translate CDPHE's strategic map into a

vehicle for action; prioritized initiatives with measurable objectives are key elements of the strategy deployment

process. OPI manages the department's strategic planning cycle, providing guidance to divisions on planning

milestones, plan preparation, development and execution.

2. Continuous Improvement Consulting and Training -- OPI is the business owner of CDPHE's Lean program. In

addition to the coaching and mentorship of the department's 14 Lean/Six Sigma Greenbelts, the OPI facilitates

cross-functional teams tasked with solving known problems, which span multiple divisions/offices or stakeholders

within the organization. OPI provides training to CDPHE leadership, management and employees in continuous

improvement methodologies including Lean/Six Sigma process improvement and management best practices.

- 3. Implementing a culture of change- Over the long-term, OPI will focus LEAN tools on areas of repeated conflict to embed a cultural change.
- 4. Accreditation OPI will lead the Department in achieving accreditation through the Public Health Accreditation

Board (PHAB). PHAB provides a means for CDPHE to identify performance improvement opportunities, to improve

management, develop leadership, and improve relationships with the community. Public health department

accreditation is defined as the development of a set of standards, a process to measure health department

performance against those standards, and reward or recognition for those health departments who meet the

standards. PHAB's public health department accreditation process seeks to advance quality and performance within

public health departments. Accreditation standards define the expectations for all public health departments that

seek to become accredited. National public health department accreditation has been developed because of the

desire to improve service, value, and accountability to stakeholders. //2014//

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

Title V funds and matching state funds support 31.50 FTE exclusively housed at the Colorado Department of Public

Health and Environment in Denver.

The Maternal and Child Health Program is directed by Karen Trierweiler, MS, CNM. It is comprised of four units. A

Fiscal and Contracts Management Section is led by Laurie Freedle. The Director of the Women's Health Unit is

Esperanza Ybarra; Rachel Hutson RN, MS, serves as the Director of the Child, Adolescent, and School Health Unit;

and Kathy Watters, MA, directs the Children with Special Health Care Needs Unit. The SSDI Coordinator is Helene

Kent. Organizational charts for the Center for Health Families & Communities is attached.

There is one paid FTE family consultant within the Health Care Program for Children with Special Health Care Needs

at the state health department in Denver. Each of the regional offices associated with the program has a family consultant.

Brief Biographical Information for Key MCH Management Staff

Karen Trierweiler, CNM, MS is the Director of the Center for Healthy Families and Communities and the state MCH

Director. Ms. Trierweiler is a certified nurse midwife with over 30 years of experience in women's health as a

clinician, educator, and public health professional. She received both her undergraduate and Master's degrees in

Nursing from the University of Colorado. Ms. Trierweiler has worked at the Colorado Department of Public Health and

Environment since 1990, originally as a nurse consultant, and formerly served as the Director of the Women's Health

Section and Title X program director.

Laurie Freedle, BS has been the Director of the Fiscal Services Unit for the Center for Healthy Families and

Communities since 2008. Her Unit administers all aspects of fiscal management for Maternal Child Health Block Grant,

Women's Health Unit, Injury, Suicide and Violence Prevention Unit, Children with Special Health Care Needs Unit, and

Child, Adolescent School Health Unit. Previously, Ms. Freedle was with the Colorado Department of Transportation

for eleven years. She was the finance director and managed over \$1 billion in state, federal, and local government

funding, as well as a \$1.3 billion bonding program.

Gina Febbraro, MPH is the Maternal and Child Health (MCH) Program Manager. Prior to joining MCH, Gina managed a

variety of MCH-related programs including the Tony Grampsas Youth Services Program at the CDPHE and a sexuality

education and teen pregnancy prevention program at Girls Incorporated of Metro Denver. Gina received her Master's

in Public Health from the University of North Carolina, Chapel Hill and her Bachelor's degree from the Pennsylvania

State University.

Kathy Watters, MA is the Director of the Children with Special Health Care Needs Unit Kathy Watters came to the

Colorado Department of Public Health in 1984 from the Colorado Department of Education's State School for the

Deaf and Blind. She received her undergraduate degree in Communication Disorders from the University of Cincinnati

and her Master's degree in Audiology from the University of Colorado-Boulder. Kathy began her career at the state

health department as the Home Intervention Program Director. She subsequently became the Hearing and Speech

Director, the Consultation Team Director, the HCP Assistant Director, and the HCP Director. She is now the Unit

Director for Children with Special Health Care Needs.

Rachel Hutson RN, MS is the Director of the Child, Adolescent and School Health Unit. Ms. Hutson has been with the

Colorado Department of Public Health and Environment since 2001, as the Director of Early Childhood Initiatives. She

now provides supervision and oversight for Early childhood Systems Development, the Coordinated School Health

Program, the School-Based Health Center Program, Adolescent Health Program, and the Tony Grampsas Youth

Services Program. Prior to working for the department she was the Pediatric Health Services Coordinator at the

Colorado Coalition for the Homeless, where she provided primary health care services as a Pediatric Nurse

Practitioner at the Stout Street Clinic in Denver. Ms. Hutson received a BA from Franklin and Marshall College and a

Masters in Nursing from Yale University.

Esperanza Ybarra, BSW, MAOM is the Director of the Women's Health Unit. Ms. Ybarra assumed the director position

this year. She directed the Nurse Home Visitor Program for over six years and worked with the Women's Health Unit

for three years. She has a variety of experiences in managing health and social services programs. Ms. Ybarra holds

a masters degree in organizational management and is a licensed social worker.

Mandy Bakulski, RD is the Prenatal Program Director in the Women's Health Unit. Ms. Bakulski is a registered dietitian

and has worked in the field of prenatal health for nearly 10 years. She received her bachelor's degree in Nutrition

Science & Dietetics from Colorado State University. Ms. Bakulski has worked at the Colorado Department of Public

Health and Environment since 2004, originally as the Director of the Prenatal Plus Program.

Gabriel Kaplan, PhD is the branch director of Epidemiology, Planning and Evaluation. Dr. Kaplan recently joined the

Department of Public Health and Environment after spending the last 5 years as an assistant professor of public

policy at the University of Colorado, Denver School of Public Affairs. Dr. Kaplan received his Ph.D. in public policy from

Harvard University in 2002 and his Masters in Public Affairs from Princeton University in 1994. He has worked as an

analyst for the US Senate, for government agencies overseas, and nonprofit clients.

Helene Kent RD, MPH is the SSDI Coordinator. She has over 20 years of experience with the Colorado Department of

Public Health and Environment, including previous tenure as the Director of the Women's Health Section within the

MCH Program. Ms. Kent was the Director of Assessment and Assurance for the Association of Maternal and Child

Health in Washington DC.

/2012/ Laurie Freedle is no longer with the CDPHE. Karen Trierweiler serves as the interim Director of the Fiscal and

Contracts Management Section. Plans are to consolidate all fiscal and administrative services at the Division versus

Center level.

Kathy Watters retired from the CDPHE.

The new Child and Youth Branch Director is Rachel Hutson RN, MS, who previously served as the Director of the

Child, Adolescent and School Health Unit. Ms. Hutson will also serve as the state's CSHCN Director.

Mandy Bakulski is now the Maternal Wellness Director.

The new SSDI Coordinator is Risa Friedman, MPH. Prior to the CDPHE, Risa worked as a Program Officer at the

Colorado Health Foundation and as a Clinical Education Coordinator at the Mountain Plains AIDS Education and

Training Center. She has contributed to health-related research projects in Denver; Quito, Ecuador; and New York

City. Risa earned a Master's in Public Health from Columbia University and a Bachelor's degree from Wesleyan

University.

Barbara Gabella, MSPH, is the director of the Epidemiology Unit. As director, Ms. Gabella created a new central unit

to expand the capacity of epidemiology in the areas of MCH, injury and chronic diseases. Previously, she served as

the state traumatic brain injury epidemiologist. Barbara has her Master of Science degree in Public Health, focusing

on epidemiology, from the University of Colorado. //2012//

//2013// Karen Trierweiler now serves as both the Section Chief for Programs and Services and the Deputy Division

Director for the Prevention Services Division. She continues to serve as the Colorado Title V

MCH Director. All fiscal

and operations staff (includes fiscal, contracts, and communications) are now consolidated at the Division versus

Center or program level.

Mike Nugent is the new Prevention Services Division Deputy Director/Fiscal and Operations Director. From 2008-

2011, Mike was the Colorado Department of Transportation's Director of Transportation Safety. In this position, he

was responsible for the safety of Colorado's traveling public through leadership and oversight of the state's

transportation safety and homeland security programs. Prior to joining state government in 2008, Mike was the

Chief of Denver Emergency Medical Services and served as the Medical Branch Director for the 2008 Democratic

National Convention. He holds a Bachelor of Arts Degree from the Metropolitan State College of Denver in Technical

Communications and a Master of Science Degree in Management from Regis University.

Danielle Shoots now serves as the Chief Fiscal Officer for the PSD, with Betina Smith-El-Senussi maintaining

oversight for the Title V Block Grant.

Gabriel Kaplan, PhD, now serves as the Director of the newly created Prevention Health Policy, Systems & Analytics

Branch. Dana Erpelding has assumed management of the Epidemiology, Planning & Evaluation Branch. She has

nine years of experience at CDPHE and has spent the past six years managing the Planning, Training, Exercise and

Evaluation and Community Outreach units for the Office of Emergency Preparedness and Response. Prior to joining

CDPHE, Dana worked as a consultant for Accenture. Dana has experience in leading efforts in project management,

assessment and evaluation, and programmatic and fiscal oversight. //2013//

/2014/Karen Trierweiler is serving as the Interim Director of the Prevention Services Division (PSD).

Irene Perez Law is now responsible for fiscal oversight of the Title V Block Grant. Prior to CDPHE, Irene held

leadership positions at various non-profit organizations. She earned her Bachelor's in Sociology at Princeton and

her Master of Public Affairs from the Lyndon B. Johnson School of Public Affairs.

Jennie Munthali is the new Program for Children with Special Health Care Needs (HCP) Unit Manager. She is

responsible for the overall management and strategic direction of HCP unit including program and budget

development. In her four years with CDPHE, she has served as a senior fiscal officer and a tobacco manager. Prior

to coming to the department, Jennie worked for an international non-governmental organization integrating HIV

treatment and care into rural hospital systems. She earned her Master's of Science in Public Health from the London

School of Hygiene and Tropical Medicine focusing on Health Systems Management.

E. State Agency Coordination

This section describes the MCH Programs relationships with a number of key partners.

Relationships among the State Human Service Agencies

Much of the statewide work accomplished by MCH staff is done in collaboration with other state agency staff,

particularly those who work with the Colorado Departments of Education; Health Care Policy and Financing; and

Human Services. MCH personnel work with other state agency staff on a daily basis through coalitions, task

forces, advisory groups, committees, and through cooperative agreements. A number of examples of state

agency coordination are provided in this section, but this list is not exhaustive. Examples are also provided in

other sections, particularly agency capacity section (III, B) and in the performance measures sections (IV C and IV D).

The Colorado Department of Human Services, in particular the Division of Developmental Disabilities is an

essential partner of the Children with Special Health Care Needs Unit within the MCH Program. Together the

agencies offer services for children served by the Colorado Department of Human Services and the Health Care

Program for Children with Special Needs. Programs include the Colorado Department of Human Services' Early

Intervention Colorado; Family Support Services Program for families with a member who has developmental

disabilities; Children's Extensive Support Waiver for Children Birth to 18 who are at high risk for out-of-home

placement; and the Children's Medical Waiver for Children Age Birth to 18 with Developmental Disabilities that

allows access to Medicaid state plan benefits regardless of parental income. The HCP program also works closely

with Early Intervention Colorado to implement HCP care coordination standards, and to define respective roles in

serving infants and toddlers with special health care needs at the community level. An HCP staff member

represents the program and the department on the Interagency Coordinating Council and the state level

Memorandum of Understanding committee.

The Women's Health Unit administers the Prenatal Plus Program on behalf of the Colorado Department of Health

Care Policy and Financing (HCPF). This program will be administered by HCPF as of July 2011.

The Colorado Department of Education is an essential partner in activities relevant to early childhood state

systems building efforts; coordinated school health model; work with school nurses; and school-based health

center activities.

The Colorado Department of Human Services, Division of Behavioral Health leads efforts to reduce underage

drinking through the Prevention of Alcohol Related Consequences (PARC) Committee (formerly called the

Underage Drinking Prevention and Reduction Workgroup). The PARC Committee is responsible for prevention and

reduction of underage drinking statewide while increasing intervention and treatment services to all youth, when needed.

Another important partners for work associated with efforts to address teen motor vehicle safety are the

Colorado Departments of Transportation; Revenue, Motor Vehicle Division; and Public Safety, State Patrol.

Relationships with Local Public Health Agencies

In recent years there has been great progress in developing Colorado's public health infrastructure. In 2008, the

Colorado Public Health Act was passed that requires each of the 64 counties to establish and maintain a public

health agency. The state health department's Office of Planning and Partnerships is responsible for carrying out

this work via the Colorado's Public Health Improvement Plan - From Act to Action, which is found at

http://www.cdphe.state.co.us/opp/cophip.html. The Office works with state- and community-based public health

systems to maintain and strengthen statewide infrastructure and capacity to provide comprehensive public health

services in the state. The MCH program works through and with the department's Office of Planning &

Partnerships to address statewide MCH issues.

The MCH Program uses a comprehensive planning process to support fifteen local public health agencies in

developing an MCH operational plan to address community needs. This planning process, developed

collaboratively with local public health partners, is a systematic way of planning, implementing and evaluating that

ensures that MCH plans at the local level are in alignment with the state-level MCH performance measures and

priority CSHCN national outcome measures. Each local public health agency engages in a threeyear cycle, that

includes one year of intensive planning, followed by two years of implementation that is documented with annual

updates to the state office. The three-year cycles are staggered so that five local public health agencies are

completing the intensive planning each year.

The state MCH program provides MCH data to each local MCH agency annually to ensure planning is data driven.

Counties use evidence-based and/or promising practice strategies with explicit goals, objectives, and activities to

address the needs identified through their planning process. Agencies also evaluate their efforts using process

and outcome evaluation measures. Go to www.mchcolorado.com for more information.

MCH Action Guides are available to assist local health agencies in developing their MCH operational plans. These

action guides provide comprehensive resources for developing strong goals and SMART objectives and for

identifying strategies and action steps to address priority health issues. Action Guides related to a variety of key

MCH issues are available on the MCH Web site.

Relationships with Federally Qualified Health Centers and Primary Care

The Colorado Community Health Network (CCHN) is the state primary care association that represents Colorado's

15 Community Health Centers (CHC) that are the backbone of the primary health care safety-net in Colorado.

CCHN has a Medical Home project that is coordinated with the CSHCN Unit's Colorado Medical Home Initiative to

develop common messaging about medical home concepts and to infuse the consumer voice. CHC's operate 138

health care delivery sites in 35 Colorado counties. Colorado's community health centers provided over 1.7 million

visits to over 419,000 low-income patients in 2008, many of them women and children. Thirteen CHCs operate 37

dental clinic sites in 21 Colorado counties and provided 175,000 visits. 90 percent of patients served by CHCs

have family incomes below 200% of the Federal Poverty Level.

The state health department's Primary Care Office works with CCHN to improve accessibility and expand primary

care services to targeted low-income and vulnerable populations. These efforts include information and data

sharing; recruitment and retention of health professionals; policy development; and assisting communities with

applying for health professional shortage area and medically underserved designations.

Relationships with Tertiary Care Facilities

The lead partner with tertiary care facilities is the state health department's Primary Care Office. Community

health centers are responsible for much of the primary care provided within Colorado. As MCH focus is mainly on

public health functions, the relationship with tertiary care facilities has changed. MCH-funded programs work to

link families to care within the community, support reforms that increase access to health care, and participate in

partnerships to assure adequate systems of care in communities to meet residents' needs.

The CSHCN program still has a strong relationship with specialty health care provision and has prioritized creating

medical homes for children and building systems of care in communities, which requires the involvement of

hospitals. The Newborn Metabolic Screening Program contracts with The Children's Hospital for follow-up services.

The Women's Health Unit participates on the Colorado Perinatal Care Council (CPCC) a volunteer, non-profit,

advisory group whose members represent a variety of professions, hospitals and organizations with an expertise

or interest in perinatal care that addresses the coordination and improvement of perinatal care services in

Colorado

Available Technical Resources

Colorado is fortunate to have a number of training and technical assistance resources available. Resources

include in-house training through the state health department and the new School of Public Health at the

University of Colorado Denver. In addition, the CSHCN Unit works with the University of Colorado JFK Partners, a

MCH LEND grantee, and Colorado Win Partners, dedicated to workforce development for people with disabilities,

to support their technical assistance needs.

Title V Program Coordination with Other Specific Programs

1. Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) is located at the Colorado

Department of Health Care Policy and Financing. The Medicaid Program contracts directly with local public health

agencies. The Health Care Program for Children with Special Needs' local and regional care coordinators work

closely with EPSDT staff. Typically, EPSDT coordinators work with public health service programs such as WIC,

prenatal, immunization services, the Health Care Program for Children with Special Needs, and other child health

initiatives. At the state level, Title V continues to work with EPSDT and to participate in the EPSDT State Advisory

Board. EPSDT personnel also serve on the Health Care Program for Children with Special Needs Medical Home

Advisory Committee.

2. Other Federal Grant Programs

The Nutrition Services Branch, that includes the Special Supplemental Nutrition Program for Women, Infants and

Children (WIC) and Child and Adult Care Food Program (CACFP), is in the same division as the MCH program. The

programs have worked jointly for many years. Current efforts are focused on increasing breastfeeding rates and

decreasing childhood overweight and obesity.

Title X Family Planning is housed within the Women's Health Unit. The MCH Block grant and Title X family planning

activities are well-integrated. Efforts to address unintended pregnancy, preconception health and teen fertility

are targeted to both family planning and MCH contractors. MCH funds are not used to fund direct family planning

services, but rather to support population-based activities around unintended pregnancy prevention.

3. Providers of services to identify pregnant women and infants who are eligible for Title XIX and to assist them in

applying for other services.

The majority of local MCH contractors for Prenatal Plus and the Nurse Home Visit Program also served as

presumptive eligibility sites for Medicaid. The Baby Care/Kids Care Program (authorized under

Colorado's Medicaid

state plan) allowed Medicaid presumptive eligibility determinations to be made at public health sites. MCH

contractors identified women and infants who were eligible for Medicaid at the local public health site (through

WIC, family planning, EPSDT, etc.), and deemed them presumptively eligible for Medicaid if the income

requirements were met. Women are referred to community resources for direct care, case management, and

other services.

4. Title V Coordination with the Social Security Administration, State Disabilities Determination Services unit.

Vocational Rehabilitation, and Family Leadership and Support Programs Social Security Administration (SSA)

Relationships with the State Determination Unit of the Social Security Administration are strong. Local level EPSDT

outreach workers make calls to families of children receiving Title XVI (SSI) to assess whether service and support

needs are being met. Referrals are made to the Health Care Program for Children with Special Needs when family

needs are complex and the EPSDT outreach worker feels that care coordination by a Health Care Program for

Children with Special Needs staff member is appropriate.

Developmental Disabilities

In Colorado, blind and disabled individuals under the age of 16 receive rehabilitation services under Title XVI

(SSI). All SSI beneficiaries under 16 years of age are automatically eligible for Medicaid. Community-based EPSDT

outreach workers call all newly enrolled SSI beneficiaries to assess whether each child's medical and support

needs are being met. In the majority of cases, Medicaid is covering all of the medical needs. HCP personnel at the

community level provide care coordination when families have more complex medical or psychosocial needs.

Vocational Rehabilitation

Relationships with Vocational Rehabilitation have been cultivated through the Colorado Interagency Transition

Team that consists of ten stakeholder agencies that work together to address youth transition to adulthood. A

representative from Vocational Rehabilitation sits on CSHCN's Unit's Colorado Health Transition Coalition. Both the

Department of Education's Special Education Section and Vocational Rehabilitation are actively involved in the

Brain Injury Steering Committee.

Family Leadership and Support

Title V has supported Family Voices Colorado financially and through membership on its board of directors since it

became an official chapter in 2001. Family Voices works with the state-level CSHCN family position and local family

consultants to implement the Family-to-Family Health Information Network provides state level family advocacy;

and represents the parent perspective in developing systems of care. The CSHCN's Unit

financially supports the

Colorado Families for Hands & Voices to engage in family advocacy, outreach to underserved populations, and

parent leadership activities.

Title V Program Coordination with other Specific Programs

The MCH Program works with many other programs. The following list is incomplete, but includes important

programs within and external to the state health department. It also includes grant-funded programs associated

with the MCH program.

The following programs are external to the health department:

The Healthier Beginnings for African-American/ Black Communities' Project is based at Tri-County Health

Department with participation from the Women's Health Unit, Healthy Start, Aurora City Council, March of Dimes,

and the community.

The Colorado Association for School-Based Health Care advocates for health care in schools for Colorado's

children and adolescents. It is a membership organization that provides policy leadership, training and technical

assistance, and quality assurance programs.

The Colorado Breastfeeding Coalition is a volunteer organization comprised of physicians, nurses, public health

officials, nutritionists, dietitians, lactation consultants, counselors, and members of the business community. The

coalition works to increase breastfeeding initiation and duration rates within the state.

Colorado Children's Healthcare Access Program is a non-profit organization devoted to ensuring that every child

enrolled in Medicaid and Child Health Plan Plus (CHP+) receives comprehensive health care from a primary care

provider, medical home team, and that all pregnant women covered by Medicaid or CHP+ receive comprehensive

prenatal services.

The Colorado Perinatal Care Council is a volunteer, non-profit, advisory group whose members represent a

variety of professions, hospitals and organizations with an expertise or interest in perinatal care. Its major focus

is the coordination and improvement of perinatal care services in Colorado.

Covering Kids and Families is a coalition aimed at reducing the number of uninsured children. It has a membership

of over 300 individuals from over 170 community-based organizations and agencies.

The Family-to-Family Health Information Center is located at Family Voices. It is a federally-funded, family-run

center established to provide information and support to families of children and youth with special health care

needs and the professionals who serve them.

Healthy Child Care Colorado provides consultation, technical assistance and training for

providers of child care in

Colorado to enhance their response to the health and safety needs of young children.

HealthyWomen/HealthyBabies is a nonprofit coalition working to improve birth outcomes through advocacy,

collaboration, research and education. The group has active workgroups addressing: access to prenatal care,

family planning and enhancing preconception care.

Oral Health Awareness Colorado (OHAC!) is the statewide oral health coalition whose members are professionals

representing a wide range of public, private and non-profit organizations interested in advancing oral health care

in Colorado.

The following programs are associated with the state health department.

The "Own Your C" youth tobacco prevention and cessation media campaign is a campaign that seeks to help

young people make the connection that their choices define who they are and who they will become.

The Teen Driving Alliance, formerly the Teen Motor Vehicle Leadership Alliance, is a multidisciplinary, statewide

coalition that formed in November 2005 with the purpose of bringing together different state agencies, local

agencies and private partners concerned about teen driving safety.

The Vaccine Advisory Committee for Colorado (VACC) is co-chaired by the Lieutenant Governor and members

represent public health, school health, child advocacy, health care, philanthropy and academia. Together they

work to increase childhood immunization coverage in Colorado.

The Colorado Advisory Council on Adolescent Health is an interdisciplinary group of adolescent health experts and

community advocates who are dedicated to improving the health and well-being of all Colorado adolescents. The

Council was commissioned in 1982 by the Department to provide guidance on priorities and use of resources to

improve the health and well-being of Colorado's young people.

The Youth Partnership for Health (YPH) is a diverse group of 14-18 year olds from across Colorado, recruited from

a variety of schools, local health agencies and community programs to provide feedback and recommendations for

public health programs, practices and policies that effect youth.

The following are grant-funded projects within the health department grouped by subject area:

The Child, Adolescent and School Health (CASH) Unit

The Children, Adolescent and School Health (CASH) Unit uses private foundation funding to provide technical

assistance to local early childhood councils related to efforts to integrate health into their local early childhood

systems building efforts.

The CASH Unit and the department of Health Care Policy and Financing are implementing a fivevear evaluation

grant of school-based health centers in Colorado funded through the Child Health Insurance Program

Reauthorization Act.

Colorado Connections for Healthy Schools is the state's CDC Coordinated School Health initiative. The

departments of health and education work together work to build state infrastructure for coordinated school

health. CDPHE provides health content expertise and resources for school representatives to integrate into the

school environment.

The Early Childhood Systems (ECCS) Grant supports a statewide alliance of early childhood partnerships working

together to create a comprehensive system for young children birth to age eight and their families. The Early

Childhood Colorado Framework and the Framework in Action State Plan were developed to guide the state's

systems-building efforts.

Children with Special Health Care Needs Unit

Colorado's Medical Home Initiative is funded by several grant awards. The initiative is dedicated to systems

development and links all the Medical Home projects in the state to assure coordination at many levels.

The HRSA State Implementation: Integrated Services for Children with Special Health Care Needs grant project

provides \$300,000 per year for three years to allow the department to assist communities to overcome local

systemic barriers through the use of medical home quality improvement teams. It also supports the goals of the

Colorado Medical Home Initiative.

The MCH Early Hearing Detection and Intervention grant project has developed hearing screening follow-up

coalitions in ten communities identified as needing to improve follow-up. Hospital birth certificate staff, early

intervention and HCP staff were members of the teams. It also allows for the integration databases including the

universal newborn metabolic screening and infant hearing screening data; the Birth Defects Monitoring Program;

immunization registry; and asthma surveillance data.

Women's Health Unit

The Women's Health Unit was selected by a private donor to receive up to five years of funding as part of the

Colorado Family Planning Initiative. Funding is used to expand family planning services and provide long acting

reversible contraception to decrease unintended pregnancies

A Tobacco Cessation Workgroup for Pregnant Women and persons receiving Medicaid was developed with the

State Tobacco Education and Prevention Partnership to address the high rates of tobacco use among these

populations.

Injury and Suicide, Violence Prevention Unit

A Child Injury Prevention Policy Plan was developed by the Injury, Suicide, and Violence Prevention Program

through a grant from CDC. The plan includes strategies to enhance Colorado's booster seat law to require that

children be secured in booster seats through age eight, or until they are at least four feet nine inches tall. The

law passed this year.

The Youth Violence Prevention Program funded by a Youth Violence Prevention Program CDC grant enhances

Colorado's capacity to address child and adolescent health through violence prevention. A Violence Prevention

Advisory Group consisting of violence prevention experts, state agency leaders, and members of private and

nonprofit prevention groups, work with the state health department on the development of a state needs and

resources assessment, followed by the construction of a state-wide strategic plan.

The Office of Suicide Prevention received another three years of funding from the Substance Abuse and Mental

Health Services Administration to continue and expand Project Safety Net. This grant allows eight community

agencies to serve twenty counties by training adults to recognize and intervene with suicidal youth, and to refer

those youth to appropriate services. Project Safety Net also includes a youth suicide prevention awareness

campaign entitled Start the Conversation.

Colorado Physical Activity and Nutrition

Funded by CDC, the Colorado Physical Activity and Nutrition Program (COPAN) is responsible for implementing the

Colorado Physical Activity and Nutrition State Plan 2010. The plan promotes healthy eating and physical activity to

successfully prevent and reduce overweight, obesity, and related chronic diseases. COPAN worked collaboratively

with the MCH units and WIC on an assessment of evidenced-based practices to impact early childhoold obesity.

/2012/ Relationships among the State Human Service Agencies

CDHS, in particular the Division of Developmental Disabilities, is an essential partner of the CSHCN programs

within the Children and Youth (C&Y) Branch.

Available Technical Resources

Additional resources include the Regional Institute of Health and Environmental Leadership (RIHEL) and

WONDERBabies.

Vocational Rehabilitation partnerships continue as outlined last year.

Family Leadership and Support

Family Voices works with the state-level Family Leader position, as well as local family consultants, to implement

the Family-to-Family Health Information Network. The C&Y Branch also collaborates with other family-centered

organizations, including Colorado Families for Hands & Voices, the Colorado Autism Society, Parent-to-Parent of

Colorado, PEAK Parent Center and the Colorado Parent Information and Resource Center (C-PIRC).

Injury and Suicide, Violence Prevention (ISVP) Unit

The ISVP Unit received a grant from the CDC to focus on developing prevention strategies for teen dating violence

in Denver, as well as a grant to improve child injury prevention policies. Additionally, the Unit piloted an

Integrated Curriculum for Youth Violence Prevention in two third grade Denver Public School classrooms. The

purpose of the curriculum is to reduce risk factors across several domains of youth violence by increasing

protective factors. These domains include bullying, suicide, sexual assault, child abuse, and dating violence. In

April 2011, the ISVP Unit was awarded four new grants through the CDC Core Violence and Injury Prevention

Program. This funding will enable Colorado to implement strategies outlined in the Colorado Injury and Violence

Prevention Strategic Plan and to focus specifically on strengthening Colorado's graduated driver license and seat

belt laws.

Oral Health Awareness Colorado (OHAC) is now called Oral Health Colorado (OHCO).

COPAN is now the Healthy Living Branch. //2012//

/2013/

Relationships among the State Human Service Agencies

The Women's Health Branch (WHB) coordinates with the Colorado Department of Health Care Policy and Financing

(HCPF) in their administration of the Prenatal Plus Program. The WHB administers complementary programs, such

as the Nurse Home Visitor and MIECHV Programs, so the two departments share resources and information for

the local agencies providing these programs. The WHB also collaborates with HCPF, the Department of Human

Services (DHS), and the Department of Education (CDE) on the state's Unintended Pregnancy Winnable Battle.

The Title V Director represents the CDPHE on the Early Childhood Leadership Commission, which works to improve

early childhood systems in the four domains of physical and mental health, early learning and parent and family

education and support.

See SPM 10 for information about the Colorado 9to25 network that is working to achieve positive outcomes for all youth in Colorado.

MCH staff coordinates resources with CDE staff to facilitate trainings and opportunities for school nurses and

public health staff, including those working with CSHCN to design improved school health care delivery models.

Examples of professional development strategies include; annual school nurse orientation, quarterly leadership

meetings and a three session leadership institute for 40 school nurses. In addition, state staff works with CDE

partners to develop infrastructure such as conducting youth surveillance, promoting policy change and evaluating

school efforts to improve the health of students.

Relationships with LPHAs

The Health Care Program for Children with Special Needs (HCP) is working with LPHAs, the University of Colorado

School of Medicine and Children's Hospital Colorado to strengthen the rural network of specialty clinics for

CYSHCN. With the goal of maximizing statewide access to specialty care, the HCP program has formed a specialty

clinic advisory committee to assist with implementation of consistent processes for coordinating clinics in rural

communities.

Relationships with Federally Qualified Health Centers and Primary Care

Community health centers (CHCs) operate 131 health care delivery sites in 34 Colorado counties. Colorado's

CHCs provided over 1.8 million visits to over 458,000 low-income patients in 2010. Fourteen CHCs operate 43

dental clinic sites in 23 Colorado counties and provided 192,000 visits to more than 79,000 patients. 94 percent

of patients served by CHCs have family incomes below 200 percent of the Federal Poverty Level.

See NPM 3 for information about the Colorado Medical Home Initiative (CMHI).

Injury, Suicide, and Violence Prevention Branch

Project Safety Net funding will end on September 30, 2012 and the Substance Abuse and Mental Health Service

Administration has not released a new funding announcement under the Garrett Lee Smith Memorial Act.

Therefore, the Office of Suicide Prevention will explore new federal funding opportunities to support youth suicide

prevention and intervention efforts in Colorado. //2013//

/2014/ Relationships among the State Human Service Agencies

HB13-1117 and 1239 authorize the transfer of several CDPHE programs to the Colorado Department of Human

Services (CDHS). In the summer of 2012, an Office of Early Childhood (OEC) was formed at the CDHS. In order to

consolidate programming for the early childhood population within one state agency, HB 1117 authorizes the

transfer of the Colorado Children's Trust Fund and Family Resource Center programs, the Home Visitation

programs, including the Maternal, Infant and Early Childhood Home Visitation Program (MIECHV) and the Tony

Grampsas Youth Services Program to the CDHS as of 7/1/13. Plans are underway to move

these programs in an

efficient and effective fashion, with the goal of continuing sound horizontal collaboration cross-agency. HB 1239

mandates the development of a youth development state plan and also transfers the interagency preventions

systems activities from CDPHE to CDHS. While CDHS will coordinate service delivery for both early childhood and

youth programming, CDPHE will continue to work at the systems and population-based level, through efforts such

as the Early Childhood Colorado Partnership and Colorado 9to25 work, to support service delivery statewide.

Relationships with Federally Qualified Health Centers and Primary Care

Community Health Centers (CHCs) operate 152 health care delivery sites in 37 Colorado counties. Colorado's

CHCs provided over 2 million visits to more than 498,000 low-income patients in 2012. Eighteen CHCs operate 53

dental clinic sites in 26 Colorado counties and provided 200,000 dental visits to more than 97,000 patients.

Ninety-four percent of patients served by CHCs have family incomes below 200 percent of the Federal Poverty

Level. The Colorado Community Health Network, representing CHCs throughout Colorado, along with other safety

net representatives, actively participate in the Medical Home Coalition and the Medical Home Community Forum.
//2014//

F. Health Systems Capacity Indicators

Health Systems Capacity Indicator 01: The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.

Health Systems Capacity Indicators Forms for HSCI 01 - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	46.4	55.0	55.3	58.7	55.0
Numerator	1646	1968	1981	2019	1888
Denominator	354990	358088	358087	343960	343476
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2012

Data shown for reporting year 2012 are calendar year 2011 hospitalizations. The denominator is smaller than previous reporting years because the population estimates were corrected to the new 2010 census data.

Notes - 2011

Data shown for reporting year 2011 are calendar year 2010 hospitalizations. The denominator is smaller than previous reporting years because the population estimates were corrected to the new 2010 census data.

Notes - 2010

Data shown for reporting year 2010 are calendar year 2009 data.

Narrative:

Health Systems Capacity Indicator 01 shows a variable annual rate of hospitalization for asthma among children

under the age of five, ranging between 46.4 and 58.7 per 10,000. Data for 2012 show 1,888 hospitalizations for a

rate of 55.0 per 10,000.

The Colorado Child Health Survey, carried out annually, provides data on asthma that contributes to an

understanding of the prevalence of the disease beyond what hospitalization data can provide. According to calendar

year 2012 survey data, 10.6 percent of children ages 1 through 14 had ever been diagnosed with asthma. Among

this group, 65.4 percent still had asthma. A computed asthma status describes 6.0 percent of children as currently

having asthma and 3.2 percent as formerly having asthma.

The Child Health Survey has been in place since 2004. Eight years of data suggests very little change since then in

the percentage of children ages 1 through 14 diagnosed with asthma. The range between 2004 and 2011 was

between 10.0 and 12.5, so that the 10.6 determined in 2012 is in the middle. The year to year changes are not

statistically significant and the rate is essentially unchanging.

Health Systems Capacity Indicator 07B: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

Health Systems Capacity Indicators Forms for HSCI 07B - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	53.8	57.0	59.2	60.5	60.7
Numerator	37126	45409	52777	59551	64277
Denominator	68974	79616	89127	98397	105972
Check this box if you cannot report the numerator					
because					
1. There are fewer than 5 events over the last year,					
and					
2.The average number of events over the last 3					
years is fewer than 5 and therefore a 3-year moving					
average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2012

Data for reporting year 2012 are from the CMS 416 annual report for the state fiscal year 2012.

Notes - 2011

Data for reporting year 2011 are from the CMS 416 annual report for fiscal year 2011.

Notes - 2010

Data for reporting year 2010 are from the CMS 416 annual report for fiscal year 2010.

Narrative:

The percentage of EPSDT eligible children age 6 through 9 who have received any dental services during the year

has been steadily increasing. The percentage of children receiving dental services grew by nearly seven points,

reaching a high of 60.7 percent in reporting year 2012 compared to 53.8 percent in reporting year 2008. This

increase can be attributed to increased training and recruitment of dental providers, public education to encourage

enrollment, and expanded coverage of Medicaid dental services. It is worth noting as well that the number of

children age 6 to 9 in the program has increased by more than 50 percent since reporting year 2008, rising from

68,974 to 105, 972. These figures underscore the progress that is being made in oral health in Colorado, with both

the number and percentage of EPSDT eligible children receiving dental care.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05	YEAR	DATA SOURCE	POPULATION		
Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State			MEDICAID	NON- MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2011	payment source from birth certificate	9.5	8.2	8.7

Notes - 2014

Data for reporting year 2012 represent calendar year 2011 births. Payment source is the principle source of payment of the delivery shown on the birth certificate, and does not indicate insurance coverage during pregnancy or imply the source of payment for prenatal care.

Narrative:

Medicaid women are at an increased risk of having a low birth weight infant compared to non-Medicaid women (9.5

percent versus 8.2 percent, respectively). The Medicaid rate is more than a full percentage point higher than the

non-Medicaid rate.

Health Systems Capacity Indicator 05B: Infant deaths per 1,000 live births

INDICATOR #05	YEAR	DATA SOURCE	POPULATION		
Comparison of health			MEDICAID	NON-	ALL
system capacity				MEDICAID	

indicators for Medicaid, non-Medicaid, and all MCH populations in the State					
Infant deaths per 1,000 live births	2010	payment source from birth certificate	6.5	5.1	5.7

Notes - 2014

The infant death rate for reporting year 2012 is based on deaths occurring among calendar year 2010 births. Payment source is the principle source of payment of the delivery shown on the birth certificate, and does not indicate insurance coverage during pregnancy or imply the source of payment for prenatal care.

Narrative:

Not unexpectedly, the Medicaid population is also at increased risk of infant death (6.5 infant deaths per 1,000

births vs. 5.1 in the non-Medicaid population). Infants born to women on Medicaid were 27 percent more likely to die

within the first year of life compared to infants born to women not on Medicaid. This is an improvement from the

previous reporting year, when Medicaid infants were 35 percent more likely to die.

Health Systems Capacity Indicator 05C: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

INDICATOR #05	YEAR	DATA SOURCE	POPULATION		
Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State			MEDICAID	NON- MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2011	payment source from birth certificate	67.4	86.2	79.4

Notes - 2014

Data for reporting year 2012 represent calendar year 2011 births. Payment source is the principle source of payment of the delivery shown on the birth certificate, and does not indicate insurance coverage during pregnancy or imply the source of payment for prenatal care.

Narrative:

Medicaid patients enter prenatal care at much later dates than non-Medicaid patients; two out of three (67.4

percent) begin care in the first trimester compared to almost nine out of ten (86.2 percent) non-Medicaid patients

who begin care early. Late entry into prenatal care can compromise early referral of patients for counseling around

gaining weight adequately and/or quitting smoking during pregnancy, two factors associated with low birth weight

in Colorado.

Health Systems Capacity Indicator 05D: Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])

INDICATOR #05	YEAR	DATA SOURCE	POPULATION		
Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State			MEDICAID	NON- MEDICAID	ALL
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2011	payment source from birth certificate	70.4	71.4	71

Notes - 2014

Data for reporting year 2012 represent calendar year 2011 births. Payment source is the principle source of payment of the delivery shown on the birth certificate, and does not indicate insurance coverage during pregnancy or imply the source of payment for prenatal care.

Narrative:

This Health Systems Capacity Indicator also reveals that there is little difference between Medicaid and non-Medicaid

women (70.4 versus 71.4) in receiving adequate care according to the Kotelchuck index. However, Colorado women

clearly fall short of meeting the Healthy People 2020 goal of 77.6 percent.

Health Systems Capacity Indicator 09B: The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes
Colorado Child Health Survey	3	Yes
Colorado Healthy Kids Survey on Tobacco	3	Yes

Notes - 2014

Narrative:

The Colorado Youth Risk Behavior Survey provides data on adolescent tobacco use every other year. The number of

surveys from the most recent year, 2011, was sufficient to yield valid statewide estimates of a number of behaviors.

There was an adequate number of surveys in 2005 and 2009, although the 2007 survey fell short.

Child Health Survey data are collected by the Health Statistics Section at the state health department and provided

annually. Results are tabulated in the spring of the year following the survey, which is conducted

on an on-going

monthly basis. Data for 2011 were available in June 2012; data for 2012 became available in June 2013. Plans are

being made to increase the sample size (currently about 1,300 surveys) in the near future, which will greatly

improve our ability to analyze data.

The Colorado Healthy Kids Survey on Tobacco (CHKS-T) was first conducted in fall 2001 and was repeated in the fall

of 2006 and 2008. With a reinstatement of funding, tobacco questions from the CHKS-T will be included in a new

comprehensive youth survey.

Beginning in December 2011, representatives of the Colorado Department of Education, the Colorado Department of

Human Services, and the Colorado Department of Public Health and Environment met to explore how three separate

school-based youth survey instruments and administration systems could be combined into a single, unified

approach. A memorandum of understanding was signed in July 2012 describing expectations, resources and

amounts to be shared and transferred among departments, and a new survey administration process. This effort

will result in a statewide comprehensive youth survey system that reduces the dollars spent on data collection while

it increases the number of students surveyed from 2,000 to 40,000. The first new survey data collection will take

place in the fall of 2013.

IV. Priorities, Performance and Program Activities A. Background and Overview

This section of the grant provides detailed information on Colorado's priorities in maternal and child health. The priorities are addressed through both national and state performance measures. There are a total of 18 national measures and 10 state measures. Each of these is discussed in detail under each measure's heading (Sections IV C and D).

An attachment is included in this section. IVA - Background and Overview

B. State Priorities

This section addresses Colorado's State Performance Measures and the attachment lists the state priority needs along with the corresponding State and/or National Performance/Outcome Measures that will be used to evaluate progress. Each of the priorities is linked with at least one and sometimes multiple state and national measures. The state measures were chosen since, in all but one case, current population data sets (e.g., vital statistics, PRAMS, the Colorado Child Health Survey, BRFSS and/or YRBS) included data that aligned with the state performance measure. Wording used in a number of the state performance measures mirrors that used in the data source.

2011 - 2015 Colorado's Nine Priorities and Ten Accompanying State Performance Measures Priority 1: Promote preconception health among women and men of reproductive age with a focus on intended pregnancy and healthy weight.

•SPM 1: Percentage of sexually active women and men ages 18-44 using an effective method of birth control to prevent pregnancy. (BRFSS)

•SPM 2: Percentage of live births to mothers who were overweight or obese based on BMI before pregnancy. (Birth certificate)

Priority 2: Improve screening, referral and support for perinatal depression.

•SPM 3: Percent of mothers reporting that a doctor, nurse, or other health care worker talked with them about what to do if they felt depressed during pregnancy or after delivery. (PRAMS)

Priority 3: Improve developmental and social emotional screening and referral rates for all children ages birth to 5.

•SPM 4: Percent of parents asked by a health care provider to fill out a questionnaire about development, communication, or social behavior of their child ages 1 through 5. (Child Health Survey - CH169)

•SPM 5: Percentage of Early Intervention Colorado referrals coming from targeted screening sources. (Early Intervention Colorado)

Priority 4: Prevent obesity among all children ages birth to 5.

•SPM 6: Percentage of live births where mothers gained an appropriate amount of weight during pregnancy according to pre-pregnancy BMI. (Birth certificate)

Priority 5: Prevent development of dental caries in all children ages birth to 5.

•SPM 7: Percent of parents reporting that their child (age 1 through 5) first went to the dentist by 12 months of age. (Child Health Survey - CH63a)

Priority 6: Reduce barriers to a medical home approach by facilitating collaboration between systems and families.

•There is no state performance measures associated with this priority. However, this priority is measured by National Performance Measure 3 -- The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (National CSHCN Survey) and National Outcome 2 -- All Children will receive comprehensive, coordinated care within a medical home.

Priority 7: Improve sexual health among all youth ages 15 -19.

•SPM 8: Percentage of sexually active high school students using an effective method of birth control to prevent pregnancy. (YRBS)

Priority 8: Improve motor vehicle safety among all youth ages 15 -- 19.

•SPM 9: Motor vehicle death rate for teens ages 15-19 yrs old.

Priority 9: Build a system of coordinated and integrated services, opportunities and supports for all youth ages 9-24.

•SPM 10: The percentage of group members that invest the right amount of time in the collaborative effort to build a youth system of services & supports. (Wilder Collaborative Factor Inventory)

C. National Performance Measures

Performance Measure 01: The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)				_	
Annual Objective	2008	2009	2010	2011	2012
and Performance					
Data					
Annual Performance	100	100	100	100	100
Objective					
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	63	60	74	73	68
Denominator	63	60	74	73	68
Data Source	CDPHE	CDPHE	CDPHE	CDPHE	CDPHE
	Newborn	Newborn	Newborn	Newborn	Newborn
	Screening	Screening	Screening	Screening	Screening
	Laboratory	Laboratory	Laboratory	Laboratory	Laboratory
Check this box if you					
cannot report the					
numerator because					
1.There are fewer					
than 5 events over					
the last year, and					
2.The average					
number of events					
over the last 3 years					
is fewer than 5 and					
therefore a 3-year					
moving average					
cannot be applied.					
Is the Data				Final	Final
Provisional or Final?					
	2013	2014	2015	2016	2017
Annual Performance	100	100	100	100	100
Objective					

Notes - 2012

Data for reporting year 2012 represent calendar year 2011 births.

Notes - 2011

Data for reporting year 2011 represent calendar year 2010 births.

Notes - 2010

Data for reporting year 2010 represent calendar year 2009 births.

a. Last Year's Accomplishments

The indicator for reporting year 2012 showed that 100.0 percent of screen positive newborns received timely follow

up to definitive diagnosis and clinical management for conditions mandated by the newborn screening program. The

target for reporting year 2012 was 100.0 percent, and the target was met.

The Colorado Department of Public Health and Environment (CDPHE) began screening for Severe Combined

Immunodeficiency (SCID) in February of 2012. The program's first abnormal newborn screen led to the diagnosis of

a child with classic SCID. Colorado was prepared to screen more than 100,000 babies before finding a case of

classic SCID, but one was diagnosed among the first 2,000 babies screened.

Research to establish high-altitude-specific newborn pulse oximetry values in order to successfully implement

newborn screening for critical congenital heart disease (CCHD) continued. This research was recommended by the

(US Department of Health and Human Services) Secretary's Advisory Committee on Heritable Disorders in Newborns

and Children (SACHDNC) who recommended screening for CCHD with the specific caveat that research needed to be

done to establish appropriate cut-offs for high altitude. (Healthy babies born at high altitude have pulse oximetry

values lower than healthy babies born at sea level, so if using cut-offs determined at sea level many healthy babies

would have an "abnormal" screen for CCHD and would require urgent and costly diagnostic testing.) CCHD

screening research pilot programs were undertaken in three hospitals.

In September 2012, the newborn screening follow-up coordinator participated in a national meeting sponsored by

Health Resources and Services Administration (HRSA) to define "case definitions and quality indicators" for newborn

screening programs. HRSA began a pilot project to have practitioners report specific data related to diagnoses, in

order to collate the results and use the information to form universal case definitions for data that will be entered

into the new HRSA-funded national newborn screening data repository, which is under development. The repository

will be administered by the HRSA-funded national newborn screening technical assistance agency NewSTEPs.

Program and IT planning continued on a project to upload newborn screening results into the existing Immunization

Registry, so physicians can access the results directly.

The newborn screening follow-up coordinator provided the data for a paper on Colorado's experience with second

screens for congenital adrenal hyperplasia, which was accepted for publication in the Journal of Pediatrics in the

coming year.

Table 4a, National Performance Measures Summary Sheet

Activities Pyramid Level of							
	DHC	ES	PBS	IB			
1. Began screening for SCID	X						
2. Continued research to establish high-altitude-specific newborn	Х						
pulse oximetry values							
3. Participated in national meeting to define "case definitions and	Х	Х					
quality indicators"							
4. Uploaded newborn screening results into existing	Х	Х	Х	X			
Immunization Registry							
5.							
6.							
7.							
8.							
9.							
10.							

b. Current Activities

The target for reporting year 2013 is 100.0 percent.

Research into establishing high-altitude cut offs for pulse oximetry to diagnose CCHD in newborns continues. Three pilot projects will conclude this year.

The Newborn Screening (NBS) Program is investigating what role CDPHE will play in implementation of newborn

screening for CCHD using existing staff and financial resources, and how CDPHE might partner with internal and

external partners to assure completion of some of the activities necessary for implementation.

The NBS Follow-Up Coordinator is participating in a pilot project to create disease case definitions for the HRSA-

funded national data depository under construction, by collecting and reporting specific data on babies diagnosed

with disease (administered by the HRSA-funded national newborn screening technical assistance agency

NewSTEPs).

The NBS Program participates in activities related to ensuring newborn screening best practices in an 8-state region,

as well as the implementation of emergency preparedness for newborn screening and telehealth for genetics

through participation on the Mountain States Genetics Regional Collaborative.

The NBS Program monitors the usefulness to practitioners of including newborn screening results in the state

Immunization Registry, and makes refinements where necessary.

c. Plan for the Coming Year

The target for reporting year 2014 is 100.0 percent.

Data from the three completed pilot studies of CCHD screening using sea-level pulse oximetry cutoffs will be used to arrive at altitude-specific guidelines for screening in Colorado.

Experience gleaned from the three CCHD screening pilot studies will be used to establish best practices for CCHD newborn screening in Colorado.

The national newborn screening data depository (NewSTEPs) will be functional and Colorado will be reporting all its diagnosed cases to the repository.

Newborn screening results on the Immunization Registry will be in a form that is usable by practitioners and the existence of this service will be widely disseminated.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	65511										
Reporting Year:	2012										
Type of Screening Tests:	(A) Receiv at least Screen	one	(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	Need Trea that Reco	Received Treatment					
	No.	%	No.	No.	No.	%					
Phenylketonuria (Classical)	64832	99.0	25	7	7	100.0					
Congenital Hypothyroidism (Classical)	64832	99.0	75	30	30	100.0					
Galactosemia (Classical)	64832	99.0	2	2	2	100.0					
Sickle Cell Disease	64832	99.0	8	8	8	100.0					
Biotinidase Deficiency	64832	99.0	1	0	0						
Cystic Fibrosis	64832	99.0	32	13	13	100.0					
21-Hydroxylase Deficient Congenital	64832	99.0	18	8	8	100.0					

Adrenal			1
Hyperplasia			

Performance Measure 02: The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)] Annual Objective and	2008	2009	2010	2011	2012
Performance Data					
Annual Performance	60	60	60	61	68
Objective					
Annual Indicator	59.1	59.1	59.1	66.5	66.5
Numerator					
Denominator					
Data Source	National	National	National	National	National
	Survey of				
	CSHCN	CSHCN	CSHCN	CSHCN	CSHCN
Check this box if you cannot					
report the numerator because					
1.There are fewer than 5					
events over the last year, and					
2.The average number of					
events over the last 3 years is					
fewer than 5 and therefore a					
3-year moving average					
cannot be applied.					
Is the Data Provisional or				Final	Final
Final?					
	2013	2014	2015	2016	2017
Annual Performance	68	69	70	71	72
Objective					

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The 2009-2010 results are not available until late 2011, so reporting year 2010 repeats the data shown for reporting year 2007, 2008, and 2009.

a. Last Year's Accomplishments

The indicator for reporting year 2012 showed that 66.5 percent of families with children with special health care

needs partner in decision making and are satisfied with the services they receive. The target for reporting year 2012

was 68.0 percent and it is unknown whether the target was met because updated data were not available for

reporting year 2012.

The Colorado Family Leadership Training Institute (FLTI) was implemented in five pilot sites statewide. This 20-week

course is designed to give parents/families tools to blend civic engagement with effective leadership on behalf of

children and families. In partnership with the developers of the program, the State Family Leader sponsored a multi-

state, national train-the-trainer event that resulted in the credentialing of 26 additional Coloradobased FLTI

facilitators. These newly trained facilitators increased the Colorado cadre of trained facilitators to include more men

and women of color, bilingual skills and a rural perspective. Additionally, the first mono-lingual FLTI class was

completed, with all related materials offered in Spanish. This class of mono-lingual Spanish speaking Family Leaders

fully participated in the State Graduation event, held at the Colorado State Capitol, as the event also featured full

interpretation to Spanish. FLTI data indicates that all participants increased their knowledge and skills related to

decision-making as a result of their FLTI involvement. Data also supports the goals, including diversity in socio-

economic status and growth in leadership skills. This directly addresses this NPM by increasing the skills, knowledge

and abilities for families to be equal partners in decision making. Several FLTI graduates/alumni are now working as

consultants and/or advisors with various systems-related partners, to assure the perspective of families is

represented in programmatic processes.

The FLTI State Civic Design Team developed and began implementation of a three year action plan. Additionally, The

Colorado Health Foundation (TCHF) awarded funding to sustain and expand FLTI, with 180 emerging family leaders

expected to graduate. The State Family Leader also supported two Family Leaders who serve as part of the FLTI

State Team, and are funded by the MCHB and TCHF grant. These contractors have been effective in providing

outreach to families, leading to greater satisfaction and increased partnership in decision-making.

Throughout last year, The State Family Leader worked closely with a variety of internal and external partners

including Early Childhood Colorado (supported by ECCS), HRSA/MCHB Region 8, Colorado's state Medicaid office and

AMCHP to increase awareness of the value of family engagement. As a result, these partner organizations have

increased their knowledge of how to assure equity in decision-making when working with families. Some of these

partnerships also increased referrals to FLTI and raised awareness regarding the value of including family leaders in

the planning and implementation of their projects.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service				
	DHC	ES	PBS	IB	
Maintained the Family Leadership Training Institute (FLTI) across Colorado		Х	Х		
2. Trained 25 additional community leaders to be credentialed as FLTI Facilitators through the national training to increase number of diverse facilitators for the FLTI		Х	X	X	
3. Solidified a HRSA/MCHB traumatic brain injury grant to support FLTI expansion		Х	Х	Х	
4. Shared the outcomes of FLTI and respective community projects of the graduates with various stakeholders			Х	Х	
5. Implemented a strong evaluation plan				Х	
6.					
7.					
8.					
9.					
10.					

b. Current Activities

The target for the reporting year 2013 is 68.0 percent.

The State Family Leader has helped mentor and identify leadership opportunities for trained Family Leaders

statewide. FLTI currently has approximately 220 graduates, adding 180 additional graduates by June 2013. Through

funding from the TCHF grant, seven local sites are currently offering FLTI. As a result of discussions related to the

hospital's dedication to family-centered care and the medical home model, Children's Hospital Colorado recently

became an official partner and sponsor of FLTI, offering funding for the FLTI class in their community. In addition to

supporting an FLTI effort in the Denver/Aurora area, Children's Hospital Colorado is receiving technical assistance

from the State Family Leader to implement processes to integrate FLTI graduates into leadership opportunities

within the hospital, resulting in several FLTI graduates being "matched" to hospital advisory councils.

The FLTI State Civic Design Team continues to implement the action plan, while the State Family Leader is

developing a marketing effort to highlight the successes of family leadership and the impact at the local, state and

national level to encourage broader adoption of family leaders in MCH. The FLTI evaluation will continue, with a focus

on measuring long term community impact and civic engagement.

The Colorado Family Leadership Summit will be the first of its kind in Colorado, bringing over 250 family leaders to

Denver.

c. Plan for the Coming Year

The target for reporting year 2014 is 69.0 percent.

Activities from the previous year will continue.

Building on strengths and current successes, the State Family Leader will continue to match FLTI graduates with

leadership opportunities, including participating in grant writing/review, serving on boards/councils and providing

training. Developing a strong alumni program will be a key strategy for the sustainability and growth of FLTI. A

process has been developed whereby stakeholders can request consultative services from an FLTI graduate. This

will be documented by a roster of FLTI graduates and their respective skills, interests and experience will be

featured on www.ColoradoFamilyLeadership.com.

Reporting the data and increased civic engagement of FLTI graduates in local communities is at the heart of the

FLTI success story. As a result, an evaluation plan was developed to collect and analyze data to determine the

ongoing civic engagement of FLTI graduates. A survey and interview process will measure civic engagement at

specific time intervals following their FLTI graduation -- six months, 12 months and 24 months.

The State Family Leader will also explore sustainable funding opportunities including a Colorado Community

Engagement Trust Fund and connecting Region 8 federal funds. A trust fund would offer a regenerative source of

funding for FLTI and other evidence-based family leadership programs. Replicating successful models already in

place in Colorado, the State Family Leader will work with a variety of stakeholders to establish a solid pathway to

develop and maintain the trust fund.

A comprehensive messaging, outreach and marketing plan will be implemented. With a fully redesigned website,

family leaders will have immediate access to leadership opportunities to assure the parent perspective is well

represented in a myriad of MCH topics. Conversely, state partners and stakeholders will also have access to

family leaders through a database featured on the website, whereby they can search for specific skills and topical

experience of Family Leaders before inviting them to participate on advisory boards, councils, etc. This will also

inform us as to where and how FLTI graduates are contributing in their communities. We will also be able to

assess the trends in how stakeholders are requesting input from family leaders.

Three additional communities were identified for expansion of FLTI and will complete their community readiness

activities with the State Family Leader to support their class launch in January 2014. The established FLTI sites

are expected to remain, which will bring the FLTI sites to a total of ten communities statewide, with approximately

200 additional graduates by June 2014.

The FLTI State Civic Design Team will continue to implement the action plan addressing curriculum refinement,

developing partnerships and identifying additional communities for expansion.

Performance Measure 03: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	51.7	51.7	51.7	52	45
Annual Indicator	48.2	48.2	48.2	43.7	43.7
Numerator					
Denominator					
Data Source	National Survey of CSHCN				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	45	46	47	48	49

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two

surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The 2009-2010 results are not available until late 2011, so reporting year 2010 repeats the data shown for reporting year 2007, 2008, and 2009.

a. Last Year's Accomplishments

The indicator for reporting year 2012 showed that 43.7 percent of children with special health care needs

received coordinated, ongoing, comprehensive care within a medical home. The target for reporting year 2012

was 45 percent and it is unknown whether the target was met because updated data were not available for

reporting year 2012.

The Children, Youth and Families Branch (CYFB) continued to lead the work of the Colorado Medical Home

Initiative (CMHI) in collaboration with the Colorado Department of Health Care Policy and Financing (HCPF). CMHI

objectives include working to build and implement sustainable systems that support quality health care for all

children and youth in Colorado; reinforcing the medical home approach as a core concept of quality health care;

promoting care coordination partnerships between families and providers; and encouraging a team approach

among all health care providers. The CMHI provides support for two key working groups. The first is the Colorado

Medical Home Coalition, which is a group of Colorado leaders focused on strategically aligning existing statewide

medical home projects, grants and initiatives. The coalition consists of representatives from the following

organizations: The Children's Hospital Colorado, HealthTeamWorks (formerly known as the Colorado Clinical

Guidelines Collaborative), the Colorado Medical Society, the Colorado Children's Healthcare Access Program,

Family Voices Colorado, ClinicNET, and the Colorado Community Health Network.

The second CMHI-supported group is the Colorado Medical Home Community Forum, a bimonthly meeting of

Colorado stakeholders representing various state and local agencies, families, health care providers and

policymakers from all over Colorado. On average, approximately 50 stakeholders participate in the meeting to

discuss and provide input on issues related to supporting the medical home approach in Colorado.

The Medical Home MCH Implementation Team developed state and local logic models and action plans for this

priority. The action plans were informed by the experiences of several key groups who have been working on

medical home issues at the community level: local HCP systems building efforts that were required in previous

MCH/HCP plans; local Early Childhood Health Integration grantees; and the local pilot communities from the MCHB

Integrated Services grant.

For FY2013, local public health agencies who participated in the MCH planning process were required to submit a

medical home local action plan. In addition, agencies were asked to include at least one objective with an early

childhood focus. This is based on 1) the importance of early identification of and support related to special needs

and 2) the opportunity to align and leverage resources with existing early childhood systems building efforts in

Colorado.

In April 2012, the Colorado Medical Home Initiative launched a new medical home website, www.medicalhomecolorado.org. The website integrated content from the CDPHE medical home website and the

HCPF medical home website, in order to centralize Colorado medical home resources and information.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service					
	DHC	ES	PBS	IB		
1. Co-led the Colorado Medical Home Initiative, in partnership				Х		
with the Department of Health Care Policy and Financing						
2. Coordinated the MCH Implementation Team for the MCH				Χ		
Medical Home Priority						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

b. Current Activities

The target for reporting year 2013 is for 45.0 percent.

As outlined in the MCH Implementation Team's Medical Home state action plan, the following strategies and activities

are currently being implemented to reduce barriers to a medical home approach:

 Mobilizing partnerships: CMHI continues to support both the Medical Home Coalition and the Medical Home

Community Forum. Examples of topics addressed by the two groups during this period include connecting Regional

Care Collaborative Organizations (RCCOs) with other community-based entities to support a medical home

approach; care coordination standards of practice; and supporting youth transition into adult systems. CMHI

continues to maintain an up-to-date medical home website to capture current state and national information that

promotes a medical home approach.

- Policy analysis: The Health Systems Unit is developing a medical home policy agenda.
- Supporting consumer voice: Staff within the CYFB continues to provide statewide coordination for the Family

Leadership Training Institute to support family leaders in communities throughout Colorado.

• Supporting local communities: Staff within the CYFB continues to provide technical assistance and training to

local public health agencies to support implementation of their local medical home action plans.

c. Plan for the Coming Year

The target for reporting year 2014 is for 46.0 percent.

The Medical Home MCH Implementation Team will continue to implement the state action plan, and support local

public health agencies in the implementation of their local action plans. In October 2013, 14 LPHAs will begin the

second year of implementation of their local action plans to reduce barriers to a medical home approach in their

community. Examples of specific areas of focus include identifying and addressing medical home barriers

experienced: by the refugee population; during NICU transition; accessing specialty care; accessing oral health

care; and accessing mental health care. Several LPHAs have elected to continue implementation of an integrated

medical home/ABCD local action plan, which is focused on reducing barriers to a medical home approach specific to

early childhood developmental screening, referral and follow up.

The technical assistance for LPHAs will continue to be provided through one-on-one consultation, as well as through

a series of technical assistance webinars and in-person meetings. Examples of on-going technical assistance topics

include strengthening partnerships with local early childhood key stakeholders for collective impact on reducing

barriers to a medical home approach; evaluating medical home partnerships; and mobilizing partners to impact

medical home policy.

The Health Systems Unit will being implementation of the medical home policy agenda, working with internal and

external partners to impact policy that promotes a medical home approach.

The MCH Program will continue to explore the implementation of a Help Me Grow state plan to provide a statewide

call-in resource number for children and youth, including those with special needs, that is more comprehensive in

scope than the current Family Healthline. This plan will involve multiple state partners and agencies who work with

children and youth. The goal is to complete an implementation plan for Help Me Grow during the next grant year.

Performance Measure 04: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

Tracking Performance Measures

	_		
[Secs 485	(2)(2)(B)(iii)	and 486	(a)(2)(A)(iii)1

Annual Objective and	2008	2009	2010	2011	2012
Performance Data					
Annual Performance	60	60	60	61	51
Objective					
Annual Indicator	59.1	59.1	59.1	49.9	49.9
Numerator					
Denominator					
Data Source	National	National	National	National	National
	Survey of				
	CSHCN	CSHCN	CSHCN	CSHCN	CSHCN
Check this box if you cannot					
report the numerator because					
1.There are fewer than 5					
events over the last year, and					
2.The average number of					
events over the last 3 years is					
fewer than 5 and therefore a					
3-year moving average					
cannot be applied.					
Is the Data Provisional or				Final	Final
Final?					
	2013	2014	2015	2016	2017
Annual Performance	51	51.5	53	54	55
Objective					

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The 2009-2010 results are not available until late 2011, so reporting year 2010 repeats the data shown for reporting year 2007, 2008, and 2009.

a. Last Year's Accomplishments

The annual indicator for reporting year 2012 showed that 49.9 percent of families with children with special health

care needs had adequate private and/or public insurance to pay for the services they need. The target for reporting

year 2012 was 51.0 percent and it is unknown whether the target was met because updated data were not

available for reporting year 2012.

The Health Care Program for Children with Special Needs (HCP) staff continued to participate with the Medicaid and

Kids and the Covering Kids and Families Coalitions to share information, simplify the public insurance application

process and identify concerns for families using public insurance.

When local county public health agency staff provides HCP Care Coordination, they assist families with insurance

coverage and/or local payer sources for services. In 2011, insurance data was recorded for 1.150 children receiving

care coordination. The data collected showed that 1,097 children had public or private health insurance at the time

of their intake interview. Children whose families reported not having any form of insurance received a care

coordination action plan with a goal of ensuring that within the next six months families were able to find coverage

for their children.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			vice
	DHC	ES	PBS	IB
1. Developed annual IA with Health Care Policy and Finance for sharing Medicaid data to assist with MCH and HCP planning				Х
2. Fostered local partnerships with RCCOs to reduce barriers to a medical home approach				Х
3. Collected insurance data for children and youth with special needs receiving HCP Care Coordination				Х
4. Provided care coordination services for CYSHCN to ensure		Х		

they seek and maintain insurance coverage		
5.		
6.		
7.		
8.		
9.		
10.		

b. Current Activities

The target for reporting year 2013 is 51.0 percent.

The CYSHCN data includes the collection of insurance data for the population receiving HCP Care Coordination. This

data will inform future programmatic decisions in order to most effectively support CYSCHN with care coordination services.

HCP staff participates with the Medicaid Kids and the Covering Kids and Families Coalitions to share information to

simplify the public insurance application process and identify concerns for families using public insurance.

The Colorado Health Care Affordability Act allows families who make too much to qualify for Medicaid or Child Health Plan Plus (CHP+) to "buy into" Medicaid coverage for their children with a disability by

paying a monthly premium based on their family's income. Qualifying children are those under age 19, who have a

qualifying disability using the Social Security Administration listings, and whose family income is below 300% of the

federal poverty level. Children enrolled in the Medicaid Buy-In Program will receive Regular Medicaid benefits with

monthly premiums ranging from \$0 to \$120. The program began July 1, 2012 and as of June 2013, there are 270

children enrolled.

c. Plan for the Coming Year

The target for reporting year 2014 is 51.5 percent.

Activities will continue for the upcoming year. The HCP program will focus on developing a strategic evaluation plan

to identify and measure the quality and impact of care coordination services on families of children with special

health care needs. During preliminary discussions, the program has identified this national performance measure as

a key outcome to measure as part of the evaluation plan.

Performance Measure 05: Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance	87.8	87.8	88	89	61
Objective Annual Indicator	87.8	87.8	87.8	60.1	60.1
Numerator	07.0	07.0	07.0	00.1	00.1
Denominator					
Data Source	National Survey of CSHCN				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	61	61.5	62	62.5	63

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The 2009-2010 results are not available until late 2011, so reporting year 2010 repeats the data shown for reporting year 2007, 2008, and 2009.

a. Last Year's Accomplishments

The annual indicator for reporting year 2012 showed that 60.1 percent of families with children with special health

care needs reported the community-based service systems are organized so they can use them easily. The target

for reporting year 2012 was 61.0 percent and it is unknown whether the target was met because updated data

were not available for reporting year 2012.

The Family Leadership Training Institute (FLTI) received funding to sustain and expand its program with 180

emerging family leaders expected to graduate (see NPM 2 for more information).

Fourteen local public health agencies (LPHAs) were required, as part of their contract with CDPHE, to develop and

implement a medical home local action plan. The action plan provides a more formal mechanism to identify and

develop a plan to reduce the barriers to a medical home approach that are experienced by children, youth and

their families. The activities in the medical home local action plan reflected community, county and multi-county

level systems building efforts. The Health Care Program for Children with Special Needs (HCP) Nurse Consultant

serves on the Medical Home MIT and provided technical assistance to LPHAs and their medical home local

coalitions to implement their action plans (see NPM 3 for more information).

The Colorado Department of Human Services (CDHS) and the Colorado Department of Education (CDE) developed

an infrastructure for local traumatic brain injury (TBI) liaisons from school districts and the community. Community

TBI liaisons are often from local HCP offices and have experience providing care coordination for Children and

Youth with Special Health Care Needs (CYSHCN). Children with traumatic brain injury were referred by LPHAs for

HCP Care Coordination. The HCP consultants at the CDPHE held two coordinating meetings with CDHS and CDE

to evaluate and strengthen the referral systems for children with traumatic brain injuries.

HCP provided support for 99 local specialty clinics in rural areas of the state through a contract with the University

Physicians, Inc (UPI) and in partnership with the University of Colorado School of Medicine and Children's Hospital

Colorado. Specialty clinics include neurology, orthopedic and rehabilitation. LPHAs provided clinic coordination

through six regional clinic coordinators in nine host communities.

The HCP Care Coordination model based on best practices in care coordination, was implemented by LPHAs

throughout Colorado. The model provides a standardized approach to care coordination that was utilized by 37

HCP offices throughout the state in 2012. New HCP Care Coordination staff from LPHAs was trained on the model

and local team leads were trained on how to use reports from the CYSHCN data system to monitor the quality

and impact of their care coordination services.

The HCP Care Coordination Nurse Consultant participated in the Colorado Care Coordination Community of

Practice workgroup. The workgroup developed a standard definition, functions and outcomes for care

coordination to be utilized as a resource by organizations providing care coordination services.

Table 4a. National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			vice
	DHC	ES	PBS	IB
Family Leadership Training Institute coordinated in four communities				Х
2. Local systems development included as part of local MCH local action plans with an emphasis on early childhood				Х
3. Development of standardized CYSHCN data system reporting tools for effective monitoring				Х
4. Continued infrastructure support for HCP specialty clinics				Х
5. Continued infrastructure support for HCP Care Coordination				Х
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2013 is 61.0 percent.

LPHAs participating in the MCH/HCP planning process are required to submit a medical home local action plan. LPHAs

are encouraged to examine the experiences of CYSHCN to inform the systemic barriers that need to be addressed.

In one community, the action plan included developing a partnership with the local hospital and moving the specialty

clinic location from the LPHA to the hospital's outpatient clinic in order to provide more space for the clinics, a closer

connection between the LPHA and the hospital and greater access to telemedicine equipment.

HCP maintains a contract with UPI and works with the University of Colorado School of Medicine and the Children's

Hospital Colorado to support HCP specialty clinics. In 2013, the HCP Consultants will work with UPI and LPHAs to

implement a more effective triage and scheduling protocol in order to improve the efficiency and accessibility for

CYSHCN in rural counties. An evaluation of the specialty clinics is underway.

All LPHAs provide resource and referral information, with LPHAs in the most populous counties providing the full

model of HCP Care Coordination services. The HCP Unit is conducting an evaluation of the quality of care

coordination services throughout the state.

The HCP team developed a diagnostic and evaluation work group to identify opportunities to

and improve access to developmental diagnostic and evaluation services

c. Plan for the Coming Year

The target for reporting year 2014 is 61.5 percent.

Activities will continue for the upcoming year.

Staff from the HCP Unit will work with University Physicians, Inc. and the Children's Hospital Colorado Telemedicine

Director to build the infrastructure and training necessary to maximize the use of telemedicine in the delivery of HCP

rural specialty clinics services. An evaluation of the new regional structure for specialty clinics will be completed in FY

2013. This will include a review of clinic usage data and survey data from families who attend clinic, local public

health staff who coordinate the clinics, physicians who refer patients to the clinics and the physicians who provide specialty care to clinics.

In 2013, the Medical Home MIT will work with the CDPHE Health Systems Unit to conduct an assessment of the local

policy initiatives included in the medical home local action plans, using this information to inform the state level policy agenda.

Performance Measure 06: The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]		1			
Annual Objective and	2008	2009	2010	2011	2012
Performance Data					
Annual Performance	47	48	48	49	44
Objective					
Annual Indicator	47	47	47	42.1	42.1
Numerator					
Denominator					
Data Source	National	National	National	National	National
	Survey of				
	CSHCN	CSHCN	CSHCN	CSHCN	CSHCN
Check this box if you cannot					
report the numerator because					
1.There are fewer than 5					
events over the last year, and					
2.The average number of					
events over the last 3 years is					
fewer than 5 and therefore a					
3-year moving average					
cannot be applied.					
Is the Data Provisional or				Final	Final

Final?					
	2013	2014	2015	2016	2017
Annual Performance	44	45	46	47	48
Objective					

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The 2009-2010 results are not available until late 2011, so reporting year 2010 repeats the data shown for reporting year 2007, 2008, and 2009.

a. Last Year's Accomplishments

The annual indicator for reporting year 2012 showed that 42.1 percent of youth with special health care needs

(YSHCN) received the services necessary to make transitions to all aspects of adult life. The target for reporting

year 2012 was 44.0 percent and it is unknown whether the target was met because updated data were not

available for reporting year 2012.

Colorado's MCH program focused on integrating efforts related to youth in transition. In recognition of the broad

definition of YSHCN set forth by MCHB, Colorado's MCH program wanted to assure that the needs of youth with

"invisible" or moderate special health care needs were considered in ongoing development of systems of care.

While systems that support youth with significant disabilities are historically well-established and

heavily

monitored, including health care and educational systems, many families report that systems to support youth

with moderate disabilities or behavioral health needs are less accessible. Therefore, MCH staff began tracking the

percentage of YSHCN on the department's youth advisory board, the Youth Partnership for Health. With this

broader definition, staff discovered that 90 percent of the YPH members have a special health care need. In

August 2012, Colorado launched Colorado 9to25 (CO9to25), a systems building initiative to address population-

based needs for youth between the age of 9 and 25. It continues the investments made in the early childhood

systems-building work aims to create and connect systems that support emerging adults, integrating the

perspectives of all youth, including YSHCN. The State Family Leader and the physician champion for the Colorado

Medical Home Iniative (CMHI), who specializes in health care transition for YSHCN participated as advisors to

CO9to25 to help address health care transition for youth.

The State Family Leader (SFL) continued to serve as a Title V and parent representative on the National Cabinet

for the National Center for Transition -- Got Transition? Working closely with the youth leader on the Cabinet, the

SFL consistently integrated the family perspective through webinars, trainings and outreach efforts. Colorado was

chosen by the National Center on Transition to implement a learning collaborative related to transitioning youth

from the pediatric health system to the adult system. In addition to the work at the national level, the SFL

participated in this local learning collaborative, including serving as a subject matter expert on the planning and

implementation team, which was directed by the CMHI physician champion mentioned above. New policies, forms,

checklists and patient welcome kits have all been developed as a result of this project. In addition, all practices

who participated in the learning collaborative now have registries to identify YSHCN as well as a policy related to

the value of a successful transition. The SFL will share lessons learned and replication strategies with the entire

Title V network.

Colorado's State Family Leader worked closely with Family Voices Colorado and the Family-to-Family Information

Center to coordinate activities and resources related to YSHCN health care transition. Family Voices of Colorado

secured a grant from a private funder to support a full time employee to work on health care transition. This staff

member worked closely on the learning collaborative noted above. This staff member served as a liaison

between Family Voices Colorado and the participating practices of the Got Transition learning collaborative.

Contract requirements with local public health agencies include objectives to address transition within care

coordination activities. The Colorado Department of Education (CDE), due to IDEA regulations, is a key partner

and made progress in including health issues as part of their resource dissemination. Further collaboration with

CDE promoted a focus on the inclusion of transition services when providing care coordination and support for

families who have a youth with traumatic brain injury.

The Colorado Medical Home Initiative promotes health care transition planning as an essential element of a

medical home approach. CMHI heavily encourages partners to consider transition a priority at the clinical and

community level. During this reporting period, strategies to support youth transition were presented and

discussed the Colorado Medical Home Coalition, which is the leadership group of the Colorado Medical Home

Initiative.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service				
	DHC	ES	PBS	IB	
Colorado launched Colorado9to25 with integration of youth with special health care needs healthcare transition			Х	Х	
2. Title V worked closely with the National Center on Healthcare Transition providing support to the State Family Leader to participate on their National Cabinet			Х		
3. A learning collaborative on healthcare transition resulted in policy changes at the clinical level		Х	Х		
4. Colorado's Medical Home Initiative promoted youth health care transition as an essential element of the medical home approach			X	Х	
5.					
6.					
7.					
8.					
9.					
10.					

b. Current Activities

The target for reporting year 2013 is 44.0 percent.

Activities related to CO9to25 will continue. To assure integration of the unique needs of YSHCN in the systems-

building effort, a workgroup meets monthly to identify and implement action steps. This workgroup includes the

CMHI physician champion, family leader and youth health specialist. A joint training opportunity was conducted for

CO9to25 youth-serving professionals on best practices related to health care transition. The Colorado 9to25 Action

Plan features activities that support youth health care transition.

The 6 Core Elements of Successful Transition, published by the National Center on Healthcare Transition was shared

with Colorado's School-Based Health Centers and Colorado's CHIPRA grant team. Colorado's SBHCs will promote

these elements in their CHIPRA grant activities.

Colorado's Medical Home Initiative featured youth in health care transition at the June 2013 community forum,

featuring youth and parent leaders who addressed health care transition as part of the life course. Family Voices

Colorado designed a transition resource/publication, the Transition Wheel, to offer guidance to families related to

age-appropriate transition activities. Family Voices Colorado, with Title V, convened a stakeholder group at

Children's Hospital Colorado to address transition from the pediatric to the adult health system.

Children's Hospital Colorado is exploring an ongoing initiative to address this issue.

c. Plan for the Coming Year

The target for reporting year 2014 is 45.0 percent.

Activities from the previous year will continue.

Collaboration with the National Center on Healthcare Transition will continue. Best practices will be identified and

disseminated to local public health agencies and other partners as a result of the Got Transition? learning

collaborative. The State Family Leader will work closely with the MCH Implementation Team dedicated to further

developing CO9to25, to assure YSHCN and the family perspectives are integrated. This will lead to an increase in

knowledge and skills in youth-serving professionals to integrate youth health care transition practices.

The State Family Leader will continue to participate on a national workgroup convened by AMCHP to address a

comprehensive approach to developing effective youth leaders, including YSHCN, within projects and activities

supported by AMCHP. Lessons learned and any subsequent promising practices gained from this work will be

integrated into CDPHE's efforts to support youth and young adults.

Ongoing collaboration will continue with key partners to assure youth in health care transition are part of a

comprehensive, youth-centered system of care. These partners include Family Voices Colorado, Children's Hospital

Colorado, local practices and the Colorado Medical Home Initiative.

Performance Measure 07: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

Tracking Performance Measures

[Secs 463 (2)(2)(B)(III) and 466 (a)(2)(A)(III)]								
Annual	2008	2009	2010	2011	2012			
Objective and								

Performance					
Data					
Annual	85	80	80	80	80
Performance					
Objective					
Annual	78.6	79.4	67.1	75.6	76.3
Indicator					
Numerator					
Denominator					
Data Source	2007	2008	2009	2010	2011
	National	National	National	National	National
	Immunization	Immunization	Immunization	Immunization	Immunization
	Survey	Survey	Survey	Survey	Survey
Check this box	- ,	-,	-,	- 7	- ,
if you cannot					
report the					
numerator					
because					
1.There are					
fewer than 5					
events over the					
last year, and					
2.The average					
number of					
events over the					
last 3 years is					
fewer than 5					
and therefore a					
3-year moving					
average cannot					
be applied.					
Is the Data				Final	Final
Provisional or				i iilal	i iilal
Final?					
i iliai!	2013	2014	2015	2016	2017
Annual	80	80	80	80	
	00	00	00	00	80
Performance					
Objective					

Notes - 2012

Data shown for reporting year 2012 are for the 4:3:1:3:3 series for calendar year 2011. This indicator represents the 4:3:1:3:3 series as defined originally, and can only be compared with the reporting year 2010 and 2011 indicators. It is not recommended for comparison to years prior to reporting year 2010 because of the changes made in the way the Hib vaccine is now measured and the vaccine shortage that affected a large percent of children.

Notes - 2011

Data shown for reporting year 2011 are for the 4:3:1:3:3 series for calendar year 2010. This indicator represents the 4:3:1:3:3 series as defined originally, and can only be compared with the reporting year 2010 indicator. It is not recommended for comparison to years prior to reporting year 2010 because of the changes made in the way the Hib vaccine is now measured and the vaccine shortage that affected a large percent of children that were included in the 2009 and 2010 samples.

Notes - 2010

Data shown for reporting year 2010 are for the 4:3:1:3:3 series for calendar year 2009 from the National Immunization Survey. Note that there was a shortage of the Hib vaccine which could be partly responsible for the drop in immunization rates between 2008 and 2009. Targets for future years are all set at 80 percent.

The Colorado 2009 rate for the 4:3:1:3:3:1 series was 65.2.

a. Last Year's Accomplishments

The annual indicator for reporting year 2012 showed that 76.3 percent of the 19--35 month olds received the full

schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus.

Pertussis, Haemophilis Influenza, and Hepatitis B. The 2012 target of 80.0 percent was not met. It should be

noted that there were modifications to the vaccine series during this time. Although the availability of newer

vaccines results in increased immunity in children, these additions pose challenges for the achievement of total

updated rates as provider and public consumer education takes time. The Immunization Program suggests that

the most beneficial data to reflect the status of Colorado's 19-35 month old children would be to report the status

of each of the 12 antigens separately (see attached table).

The Colorado Immunization Information System (CIIS) is a confidential, population-based, computerized system

that collects and consolidates vaccination data for Coloradans of all ages from a variety of sources. The CIIS was

replaced with a web based system with a more robust, stable and modern immunization registry application.

Over the past year, more users and viewers were added to the system. Most school districts are able to view

student immunization records and some add new information for students, including preschool students, who

present accurate records. This access improved the accuracy of student level immunization rates for schools.

The Colorado Immunization Program created an improved de-identified data collection methodology for the school

immunization survey. The new survey complies with the provisions of the Family Education Rights and Privacy Act

(FERPA) and Colorado Revised Statute 25-4-906(3) that ensure the required immunization of school aged children

is achieved. The 2011/2012 results found that 78.6 percent of kindergarten students received all required

immunizations for school entry and 84.3 percent were in compliance with Colorado state law by either receiving

all required immunizations or by taking a medical, religious or personal exemption or were in the process of being

immunized at the time of the audit.

The Colorado Immunization Section established the Child Health Inspection Standards (CHINS) project in early

2012 to illuminate immunization and infection control best practices in the child care setting through collaboration

between environmental health and public health nursing staff. It also supported local public health agencies that

complete child care inspections to develop and implement useful systems and sustainable models that can be

shared throughout the state to improve immunization compliance and infection control in the child care setting.

Many child care centers (CCCs) were found to be unaware or under-informed about immunization requirements.

The collaboration between Environmental Health (EH) or the Department of Human Services (DHS) and public

health nursing was intended to increase collaboration, decrease duplication of services and create efficient

systems that promote healthy conditions in the child care setting.

Tri County, the largest public health agency in Colorado, services three highly populated counties. This agency

participated in the CHINS to improve up to date (UTD) rates for children aged 19 to 35 months, attending CCCs.

A total of 202 CCCs were assessed through partnered visits with the environmental health staff reviewers. The

immunization records of 13,322 children were audited for complete and UTD immunization data. During this audit

year, 126 centers (62 percent) met the standard of 80 percent of children UTD for age on the first visit by the

nurse. Centers that did not meet the standard were provided technical assistance and revisited. Of the 76

centers that needed more than one visit, the final percent of children UTD was 90 percent (a 17 percent

increase).

In April 2012, the Colorado Immunization Program (CIP) initiated a campaign to highlight the harms associated

with delayed and "alternative" immunization schedules that gained popularity in recent years. CIP reached out to

parents and providers to discuss these schedules and the parental fears and misconceptions that have

contributed to their popularity. Using the "Immune for Good" campaign, media outreach, and public speaking

opportunities, CIP focused on the importance of vaccinating children on time and the strong safety profile of

childhood immunizations.

An attachment is included in this section. IVC NPM07 Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities		Pyramid Level of Service					
	DHC	ES	PBS	IB			
1. Partnered with schools for required vaccine rates surveillance			Χ	Χ			
2. Funds provided to local public health agencies to increase	Х	Х	X	Х			
vaccine coverage							
3. Implemented of new web based CIIS (registry)				Χ			
4. Focused media campaign for parents and providers			Х	Х			
5. Funds Provided to LHAs to work with childcare settings		Х	Х	Χ			
6.							
7.							
8.							
9.							

10.

b. Current Activities

The target for reporting year 2013 remains at 80.0 percent with the recommendations that Colorado children have

vaccinations for 12 diseases by the age of 35 months, including Hepatitis A, Pneumococcal disease and Varicella.

New data will be available in September 2013.

The Colorado Immunization Program has conducted the school surveillance survey to assess immunization rates of

kindergartners (data not yet available).

The CIIS continues to be used to collect vaccination data. As of March 2013, 99 percent of public health

departments, 99 percent of community health clinics, 99 percent of rural health clinics, 90 percent of pediatric clinics,

70 percent of family practice clinics, 61 percent of hospitals and 82 percent of Vaccine for Children Clinics in Colorado

are linked with the CIIS. Additionally, 86 percent of school districts access CIIS. CIIS has started outreach and

implementation to Colorado's more than 4,000 licensed child care centers.

Improving Diptheria, Tetanus and Pertussis (DTaP) vaccine coverage for kindergartners was selected as one of

CDPHE Winnable Battles. The Immunization Program has awarded funding to LPHAs to improve immunizations in

childcare settings through the use of Childcare Inspection Standards (CHINS).

MCH continues to partner with the Immunization Program to provide funding for Tri County Department of Public

Health to expand the CHINS, child care project focused on improved updated vaccine rates for children attending

child care centers.

c. Plan for the Coming Year

The target for reporting year 2014 will be 80.0 percent for each individual antigen that is recommended for 19--35

month old children. This includes the additional antigen pneumococcal conjugate vaccine (PCV) (see attached table).

Activities will continue from the previous year including enhancing local partnerships between local public health,

schools and child care facilities to monitor completed immunization certificates for required immunizations, work with

childcare settings to improve immunization rates, provision of offsite vaccine clinics and provision of educational

information related to the efficacy of childhood vaccine.

Both state and local public health agencies will continue to provide the latest immunization information to providers.

staff and parents. In collaboration with the Colorado Immunization Information System (CIIS) staff, public health will

continue to engage providers to utilize the updated CIIS registry system. The goal for Colorado is 100% of all

vaccine providers.

The Vaccine Advisory Committee for Colorado (VACC) will continue with their work plan activities related to: Provider

Education and Public Awareness and Education. Using the Immune for Good campaign, media outreach, and public

speaking opportunities, the Colorado Immunization Program will continue focusing on the importance of vaccinating

children on time and the strong safety profile of childhood immunizations.

Performance Measure 08: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]	1	l .	1	1	1
Annual Objective and	2008	2009	2010	2011	2012
Performance Data					
Annual Performance	22	21.5	21	19.5	17
Objective					
Annual Indicator	22.1	21.4	19.9	17.4	14.0
Numerator	2200	2142	1971	1688	1362
Denominator	99489	100252	98871	97252	97123
Data Source	Birth	Birth	Birth	Birth	Birth
	Certificates	Certificates	Certificates	Certificates	Certificates
Check this box if you					
cannot report the					
numerator because					
1.There are fewer than 5					
events over the last year,					
and					
2.The average number of					
events over the last 3					
years is fewer than 5 and					
therefore a 3-year moving					
average cannot be					
applied.					
Is the Data Provisional or				Final	Final
Final?					
	2013	2014	2015	2016	2017
Annual Performance	13.5	13	12.5	12	11.5
Objective					

Notes - 2012

Data shown for reporting year 2012 are calendar year 2011 births. These data are available from the Colorado Health Information Dataset (CoHID) at http://www.chd.dphe.state.co.us/cohid/Default.aspx.

Notes - 2011

Data shown for reporting year 2011 are calendar year 2010 births. These data are available from the Colorado Health Information Dataset (CoHID) at http://www.chd.dphe.state.co.us/cohid/Default.aspx.

Notes - 2010

Data shown for reporting year 2010 are calendar year 2009 births. This data is provided in the Colorado Births and Deaths document available at

http://www.cdphe.state.co.us/hs/mchdata/mchdata.html.

a. Last Year's Accomplishments

The annual indicator for reporting year 2012 showed a teen birth rate of 14.0 per 1,000. The target for reporting

year 2012 was 17.0 per 1,000 and the target was met.

CDPHE released Youth Sexual Health: A Call to Action, a tool and resource for communities to take action to

improve youth sexual health. This document, created in partnership with youth and communities across Colorado,

includes research, guidance and a number of evidence-based strategies that communities can incorporate into

their own community action plan. Feedback was gathered through youth interviews, focus groups, community

conversations, a statewide survey and a public comment period. The Call to Action is structured using the socio-

ecological model (spheres of influence) and gives strategy recommendations for each level or sphere - individual,

family network, community and policy/system. The social determinants of health and positive youth development

frameworks are also integrated throughout.

MCH staff continued to partner with The Colorado Initiative to Reduce Unintended Pregnancies and Vermilion Inc.

on the public awareness campaign, Beforeplay, which launched in February 2012. Campaign materials are placed

in various media across the state (see SPM 1 for more information). The website (www.beforeplay.org) provides a

clinic locator and interactive reproductive health information for youth, parents, men, women and health care

professionals.

In January 2012, Colorado announced "unintended pregnancy" as one of its 10 Winnable Battles. Prevention of

teen pregnancy is included in this Winnable Battle. The unintended pregnancy Winnable Battle has a Google

Group listserv for sharing information and quarterly meetings with other agency partners. Local public health

agencies have also identified preventing unintended pregnancy as a priority.

LARC use among young women served by the Title X Family Planning Program ages 15-19 more than doubled

from 2,444 users in 2009 to 5,040 users in 2012. During the same time period, Colorado experienced a 34

percent decline in the teen fertility rate and a 45 percent decline in the number of repeat (2nd order or higher)

births to teens.

Other MCH action plan items included researching parent/child communication curriculums, which CDPHE will be

implementing regionally over the next year, and convening the Youth Sexual Health Team, which is an inter-

agency workgroup to increase alignment of statewide work.

CDPHE staff contributed to Colorado Youth Matter's annual report, the "State of Adolescent Sexual Health in

Colorado," which uses CDPHE data to provide a brief summary of relevant state and national data, along with

providing a picture of how Colorado has progressed over time.

MCH staff served on the planning committee of the first "Sexual Health Across the Lifespan" conference, working

to ensure that youth sexual health was a prominent aspect of the conference.

MCH staff worked with two MPH graduate students to conduct two assessments to support the MCH state action

plan. The first was a scan of parent-child communication interventions that helped determine the most

appropriate trainings to hold across the state. The second was a scan of youth sexual health policies in place at

the state-level and within Denver and Jefferson Counties. This scan includes the specific policy language, coupled

with a "Simply Stated" section so it is easy to understand.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service				
	DHC	ES	PBS	IB	
Released statewide youth sexual health plan				Х	
2. Planned sexual health across the lifespan conference				Х	
3. Compiled information on parent/child communication				Х	
curriculums					
4. Supported the release of reports relevant to youth sexual				Х	
health					
5.					
6.					
7.					
8.					
9.					
10.					

b. Current Activities

The target for reporting year 2013 is 13.5 per 1,000.

CDPHE's Youth Sexual Health: A Call to Action was released at events in Denver and Pueblo that included both

youth and adult participants. CDPHE presented the Call to Action and discussed state sexual health plans with other

state and national partners at a National Coalition of STD Directors' meeting. Staff continues to provide technical

assistance on implementing strategies from the Call to Action and continue to convene the Youth Sexual Health

Team comprised of three other state agencies -- Colorado Departments of Education, Human Services and Health

Care Policy and Financing.

MCH staff successfully advocated for the inclusion of sexual health education questions in the department's

statewide Child Health Survey. These will serve as a baseline toward increased parent-child communication on

sexual health topics. Additionally, MCH staff contracted with a statewide technical assistance provider, Colorado

Youth Matter, to conduct parent-child communication/ connectedness trainings.

MCH staff hired two Youth Advisor positions, one of which is focusing on improving youth sexual health. One of her

projects includes working in partnership with Family Planning staff to improve the "youth-friendliness" of Title X clinics.

c. Plan for the Coming Year

The target for reporting year 2014 is 13.0 per 1,000.

Activities will continue from the previous year.

Staff will build off of the success of Denver Health's Westwood Speaks project, which was funded by the

Preventative and MCH Block Grants. This project modified a parent-child connectedness curriculum and paired it with

a communication curriculum. Since it has shown successful results, CDPHE and its partners plan to replicate it across

the state through a contract with Colorado Youth Matter.

MCH staff will continue partnering with Family Planning staff at CDPHE on a project to help improve the "youth

friendliness" of Title X clinics. The information learned from the pilot site will be shared with other clinics and joint-

learning opportunities will be convened.

CDPHE will continue to convene the Youth Sexual Health Team. The team is choosing to focus its efforts on

parent/family engagement, education and connectedness regarding youth sexual health in order to build an

infrastructure for "askable adults" across the state. This focus not only supports several strategies listed in the Call

to Action's statewide logic model, but it also aligns with the MCH action plan.

CDPHE will continue its work around the Winnable Battle of unintended pregnancy. In order to fully address this

topic, the department is focusing on sexual health across the lifespan and is aiming to change social norms around the topic.

Local Public Health Agencies will continue to use the Call to Action in planning efforts and participate on the Youth

Sexual Health Team. They will also partner with MCH staff to outreach and support local parentchild communication

trainings. Boulder will continue to refocus a local youth sexual health coalition to focus on the county's population

based approaches, while Denver continues to work to publish the results of the parent-child connectedness

curriculum they implemented in Denver's Westwood neighborhood.

Performance Measure 09: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)					
Annual Objective	2008	2009	2010	2011	2012
and Performance					
Data					
Annual Performance	36	38	38	40	46
Objective					
Annual Indicator	35	37.1	37.1	44.9	44.9
Numerator					
Denominator					
Data Source	2006-2007 CO Basic	2006-2007 CO Basic	2006-2007 CO Basic	2011-2012 CO Basic	2011-2012 CO Basic
	Screening Survey	Screening Survey	Screening Survey	Screening Survey	Screening Survey
Check this box if you cannot report the					,
numerator because 1.There are fewer					
than 5 events over the last year, and					
2.The average number					
of events over the last 3 years is fewer than 5					
and therefore a 3-year					
moving average					
cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	47	48	49	50	51

Notes - 2012

Data for reporting year 2012 are final 2011-2012 Basic Screening Survey results for a representative sample of third graders. The survey will be conducted again in 2016.

Notes - 2011

Data for reporting year 2011 are final 2011-2012 Basic Screening Survey results for a representative sample of third graders. The survey is conducted every three to four years.

Notes - 2010

Data for reporting year 2010 are final Basic Screening Survey data from the 2006-2007 school year for a representative sample of 3rd graders. The data repeat the data reported for 2007 since the survey is conducted every three to four years. The 2010-2011 survey results will be available for reporting year 2011. Since new results were not available for reporting year 2010, the annual performance objectives were kept the same.

a. Last Year's Accomplishments

The indicator for reporting year 2012 is the same as 2011, 44.9 percent of third grade children in Colorado have

dental sealants on at least one permanent molar tooth. The target for reporting year 2012 was 46.0 percent and it

is unknown whether the target was met because updated data were not available for reporting year 2012.

In May 2012, CDPHE staff and partners completed an "in-mouth" survey of approximately 6,000 kindergarteners and

3rd graders statewide. A survey findings report was released to partners, which included a description of

improvements in progress toward the target and also the reduction of inequities identified in schools with high free

and reduced lunch (FRL) utilization. The results illustrated that there was no significant decrease in dental caries

experiences in kindergarteners or 3rd graders. Fewer children, however, have untreated cavities and less frequent

urgent oral health needs, which provides evident that more children had access to a dental home.

While progress has been made in expanding the "Be Smart and Seal Them" school sealant program, loss of the

HRSA MCH Targeted Oral Health Service System project grant caused a decline in uniform data collection and

reporting to the state. In the 2011-2012 school year, CDPHE contracted with one sealant provider, which served 84

schools with 2,697 children, placing sealants on 1,840 of them. This is approximately 50% fewer children who were

provided dental sealants than in 2010-2011.

The Oral Health Unit (OHU) loans mobile dental units, operator chairs and over-head dental lights to new school

sealant programs in order to help defray program start-up costs. In 2011-2012, equipment was loaned to the

Aspen to Parachute Dental Coalition. An additional unit was loaned to the Northeast Colorado Health Department.

CDPHE has requested funds from the Centers for Disease Control and Prevention's Division of Oral Health to

purchase four additional sealant units for this purpose.

CDPHE applied for and received an HRSA Oral Health Workforce grant to support community oral health

assessments, including access to school sealant programs.

CDPHE analyzed existing oral public health legislation and proposed modifications to existing health department

statutes, including creation of an oral health community program, including sealant programs. CDPHE worked with

stakeholders and the Governor's Office to draft legislative language to be presented during the 2013 legislative

session.

Table 4a, National Performance Measures Sur	ımmary S	heet
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|--|

	DHC	ES	PBS	IB
Received HRSA local public health planning grants to				Х
increase reach of school sealant programs				
2. Loaned dental equipment to defray start-up costs		Х		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2013 is 47.0 percent.

The 2011-2012 school survey oral health report was disseminated to stakeholders and used for grant applications

and data presentations. A series of mini-webinars assisted dental providers enrolling in Medicaid and SCHIP programs.

The Community Oral Health Program's oral health bill passed in 2013 and is expected to help support NPM 9

activities through the facilitation of private donations and the prioritization of a statewide sealant system. Work

began in April to streamline processes used to support sealant providers.

In August 2013, CDPHE, Delta Dental Foundation and the state coalition convened stakeholders to provide training

for sealant programs. Five HRSA Workforce grantees have contract requirements with CDPHE to support school

based sealant programs in 15 counties. CDPHE used CDC funds to purchase four portable sealant units to loan to

new sealant providers.

In the 2012-2013 school year, CDPHE contracted with one sealant provider, which served 84 schools, screened

1,723 children and placed sealants in 1,103 of them, about 40 percent fewer children than in 2011-2012.

Colorado's Medicaid and CHP+ offices implemented the CMS action plan, which requires an increase in sealant

utilization among the insured and a 10 percent increase in preventive dental visits in children. During 2013, state

legislation passed allowing Medicaid to reimburse dental risk assessments and fluoride varnish for children up to age 20.

c. Plan for the Coming Year

The target for reporting year 2014 is 48.0 percent.

Activities described above will continue.

The CDPHE Sealant System priority 2016 goal is to build and implement a uniform, data-driven and culturally

sensitive statewide sealant system to cover 75% of eligible schools by 2016. CDPHE will work with school-based

health centers, the state oral health coalition, the Colorado Department of Education, sealant providers, and other

partners to boost enrollment in school sealant programs. These activities of the state will minimize administrative

processes for providers.

CDPHE and the state oral health coalition will create a long-term plan to add other necessary components to the

data collection system. This will help decrease sealant providers' administrative time required for reimbursement.

Activities which support this plan may be included in an RFP for a third party administrator of the state Medicaid

benefit for children. Additionally, a data collection system and a billing system may be linked to the Colorado

Regional Health Information Organization, which is creating a centralized electronic database of patient information

to ensure information follows the patient.

CDPHE will support the Medicaid and CHP+ action plan goal of increasing sealants by 10% in five years. OHU staff

will work with the Medicaid office on strategies to increase utilization of preventive oral health visits. The Medicaid

children's dental benefit policies will be reviewed and updated in FY 2014 with support from CDPHE staff.

CDPHE will support policies that will increase enrollment in school screening and sealant programs, such as training

medical providers to provide risk assessments and varnish up to age 20. CDPHE will also propose other policies to

increase access to dental homes and support the creation of screening programs.

Performance Measure 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	3	2.5	2.4	2.2	1.9
Annual Indicator	2.7	2.6	2.3	2.0	2.1
Numerator	28	27	24	20	22
Denominator	1019648	1036835	1040402	1025217	1034643
Data Source	Death certificates				
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year,					

and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	1.8	1.7	1.6	1.5	1.5

Notes - 2012

Data shown for reporting year 2012 are calendar year 2011 deaths. The data were retrieved from the Colorado Health Information Dataset (CoHID) at

http://www.chd.dphe.state.co.us/cohid/Default.aspx. Annual performance objectives were not changed since this rate is based on a low number of deaths causing it to fluctuate.

Notes - 2011

Data shown for reporting year 2011 are calendar year 2010 deaths. The data were retrieved from the Colorado Health Information Dataset (CoHID) at http://www.chd.dphe.state.co.us/cohid/Default.aspx.

Notes - 2010

Data shown for reporting year 2010 are calendar year 2009 data representing deaths from all motor vehicle injuries for children from birth through age 14. The data were retrieved from the Colorado Health Information Dataset (CoHID) at http://www.cdphe.state.co.us/cohid/.

a. Last Year's Accomplishments

The indicator for reporting year 2012 showed 2.1 deaths per 100,000 children ages 14 years and younger caused

by motor vehicle crashes. The target rate for reporting year 2012 was 1.9 per 100,000 children, and the target

was not met. In 2012, a total of 22 deaths among children ages 14 years and younger were due to motor vehicle crashes.

During the first year of the Motor Vehicle Policy grant, the Injury, Suicide and Violence Prevention (ISVP) Branch

expanded the policy subcommittee to include additional policy partners and renamed the group the Injury and

Violence Policy Committee (IVPC). The ISVP Branch worked with the IVPC to expand the Policy Action Plan to

include strategies related to establishing primary seat belt legislation. Additionally, the ISVP Branch worked with

the Epidemiology, Planning and Evaluation (EPE) Branch to develop an associated evaluation plan.

The ISVP Branch and the Violence and Injury Prevention (VIP) Network (formally ICPG) continued to promote seat

belt use for all occupants of motor vehicles and monitored motor vehicle-related legislation during the 2012

legislative session.

The ISVP Branch and the VIP Network developed a collaborative website (www.vipreventionnetworkco.com) to

house injury information and resources.

ISVP staff continues to serve as a board member on the State CPS Advisory Board.

In 2012, the Colorado Department of Public Health and Environment (CDPHE) named motor vehicle safety as one

of Colorado's Winnable Battles, public health priorities where progress can be made in the next five years.

Although motor vehicle crashes have declined significantly over the past 15 years, it remains one of the leading

causes of injuries and deaths in Colorado. To continue to see decreases in motor vehicle-related health

outcomes, state and local partners must work together to implement evidence-based policy strategies known to

decrease motor vehicle injuries and deaths.

In order to garner local-level support for Colorado's motor vehicle Winnable Battle and to increase knowledge

about prevention strategies, CDPHE partnered with members of the Colorado Teen Driving Alliance (CTDA) to host

a Motor Vehicle Winnable Battle Academy.

Ninety-six participants represented a variety of disciplines including: public health, hospital systems, law

enforcement, schools, local traffic safety coalitions, insurance companies, and small businesses. Additionally.

several teams included parents and teens as members. Participants increased their understanding about why

motor vehicle safety was named as one of Colorado's 10 Winnable Battles and had the opportunity learn about

program and policy activities occurring around the state. Local teams worked with their mentors to refine the

community-specific motor vehicle problem they identified in their applications using available data. Teams also

conducted stakeholder analyses to identify where they needed to develop partnerships. Teams ultimately created

local level action plans to take back to their communities.

The Colorado Child Fatality Prevention State Review Team conducted comprehensive reviews of motor vehicle

death cases that involve children ages 0-14 from 2009 and 2010. The team identified strategies to prevent child

motor vehicle deaths and made recommendations to the Colorado General Assembly in their Annual Legislative

Report. Motor vehicle-related recommendations included: 1) establishing a statutory requirement that allows for

primary enforcement of the seat belt law, making it possible for a driver to be stopped and issued a citation if

anyone in the vehicle is not properly restrained; and 2) strengthening Colorado's graduated drivers license lay by

increasing the driving age to 17 and expanding the curfew hours to 10 p.m. to 5 a.m.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyram	id Leve	of Serv	rice
	DHC	ES	PBS	IB

Coordinated and maintained the Injury and Violence Policy Committee		Х
Promoted seat belt use through the Violence and Injury		X
Prevention Network		^
3. Served on the state Child Passenger Safety Advisory Board		Χ
4. Conducted reviews of motor vehicle death cases that involve		Χ
children ages 0-14 through the Child Fatality Prevention System		
State Review Team		
5. Added child passenger safety questions to the 2013 Child		Х
Health Survey		
6.		
7.		
8.		
9.		
10.		

b. Current Activities

The target for reporting year 2013 is 1.8 deaths per 100,000 children age 0-14.

The ISVP Branch is implementing the Year Two activities outlined in the Motor Vehicle Policy Plan. This includes: 1)

building state-level partnerships; 2) educating about existing laws; 3) maintaining motor vehicle data systems 4)

providing technical assistance to partners; and 5) hosting a workshop to develop new strategies to increase seat

belt use.

ISVP promoted seat belt use for all motor vehicle occupants, monitored motor vehicle-related legislation during the

2013 session, and educated decision-makers on the impact of primary seat belt laws to prevent death.

ISVP included questions on the 2013 Child Health Survey to assess the number of parents who properly

restrained their children in booster seats to compare with baseline data from 2010.

The ISVP Branch expanded the collaborative website (vipreventionnetworkco.com) to include more partners'

information and resources.

ISVP staff continued to serve on the State CPS Advisory Board.

The Child Fatality Prevention State Review Team is conducting comprehensive reviews of motor vehicle fatalities from

2011 involving children age 0-14. The team identified strategies to prevent child motor vehicle deaths, such as

establishing car seat fit stations at Head Start locations. In May 2013, legislation passed that moved the child death

review process to the local level. Local health departments will begin reviewing child deaths in 2014.

c. Plan for the Coming Year

The target for reporting year 2014 is 1.7 deaths per 100,000 children age 0-14.

The ISVP Branch will implement the Year Three activities outlined in Colorado's Motor Vehicle Policy grant and the

Motor Vehicle Policy Plan. Activities will include: 1) building state-level partnerships; 2) educating about existing child

passenger safety laws; 3) maintaining monitoring data systems related to child passenger safety; 4) educating the

public on the data related to child passenger safety; 5) providing technical assistance to local partners; 6) recruiting

Injury Prevention Winnable Battle Champions around the state working on evidence-based motor vehicle safety

issues; and 7) increasing the number of grant programs funding evidence-based projects at the local level.

The ISVP Branch and the Violence and Injury Prevention (VIP) Network will continue to promote seat belt use by

partnering with the Colorado Department of Transportation to develop and disseminate communication materials to

educate the public and key decision makers about the evidence that seat belts save lives and reduce costs. The

ISVP Branch will also monitor motor vehicle-related legislation during the 2014 legislative session. Branch staff will

implement the action steps outlined during the 2013 planning workshop to increase statewide support for primary

seat belt legislation. ISVP Branch will conduct monthly trainings throughout the year to increase staff and local

partner capacity to affect policy changes related to motor vehicle safety.

The ISVP Branch will use information gathered from the 2013 Child Health Survey related to how many parents

properly restrained their children in booster seats to guide educational efforts in the next year.

The ISVP Branch and the VIP Network will continue to distribute motor vehicle news and information through a

dedicated section on the VIP Network website (www.vipreventionnetworkco.com).

ISVP staff will continue to serve as a board member on the State CPS Advisory Board.

The Colorado Child Fatality Prevention State Review Team will conduct comprehensive reviews of motor vehicle

death cases from 2012 that involve children ages 0-14. The team will identify strategies to prevent child motor

vehicle deaths and will make recommendations to the Colorado General Assembly, state agencies, and community

organizations. Key strategies that have been identified in the past include, enhancing Colorado's booster seat and

seat belt laws and increasing the number of permanent car seat fit stations.

Performance Measure 11: The percent of mothers who breastfeed their infants at 6 months of age.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual	2008	2009	2010	2011	2012
Objective and					

Performance					
Data	40	50	00	00	00
Annual Performance	43	50	60	60	60
Objective					
Annual	48.2	59.5	57.1	52.4	56.9
Indicator	40.2	39.3	57.1	32.4	30.9
Numerator					
Denominator					
Data Source	2007	2008	2009	2010	2011
Data oodi.oo	National	National	National	National	National
	Immunization	Immunization	Immunization	Immunization	Immunization
	Survey	Survey	Survey	Survey	Survey
Check this box	,	,	,	,	,
if you cannot					
report the					
numerator					
because					
1.There are					
fewer than 5					
events over the					
last year, and					
2.The average number of					
events over the					
last 3 years is					
fewer than 5					
and therefore a					
3-year moving					
average cannot					
be applied.					
Is the Data				Final	Provisional
Provisional or					
Final?					
	2013	2014	2015	2016	2017
Annual	60	60	60	62	62
Performance					
Objective					

Notes - 2012

Data shown for reporting year 2012 are breastfeeding data collected by the National Immunization Survey for infants born in 2009 (see

http://www.cdc.gov/breastfeeding/data/reportcard.htm). These data represent all breastfeeding (not just exclusive breastfeeding) at six months of age. The annual indicator is provisional.

Notes - 2011

Data shown for reporting year 2011 are breastfeeding data collected by the National Immunization Survey for infants born in 2008 (see

http://www.cdc.gov/breastfeeding/data/reportcard.htm). These data represent all breastfeeding (not just exclusive breastfeeding) at six months of age. The annual indicator is provisional. 4-4-2013: Added final rate for 2008 births.

Notes - 2010

Data shown for reporting year 2010 are breastfeeding data collected by the National Immunization Survey for infants born in 2007 (see

http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm). These data represent all breastfeeding (not just exclusive breastfeeding) at six months of age. The percentage is provisional.

4-4-2013: Added final rate for 2007 births.

a. Last Year's Accomplishments

The indicator for reporting year 2012 showed that provisionally 56.9 percent of mothers breastfed their infants at

six months of age. The target for reporting year 2012 was 60.0 percent and the target was not met. In spite of

not meeting the performance measure target, Colorado ranked first among all states with 26.6 percent of

mothers exclusively breastfeeding at six months.

To improve evidence-based maternity practices shown to improve breastfeeding exclusivity and continuation in

hospitals, CDPHE sponsored, in partnership with several organizations, Colorado's first Hospital Breastfeeding

Summit targeted to hospital leaders and mid-level managers. The Summit met its goals and drew 140 attendees

representing 40 hospitals that deliver over 93 percent of Colorado's births. Attendees shared experiences, best

practices, challenges, and success in embedding the components of the 10 Steps to Successful Breastfeeding;

and 25 hospitals submitted action plans to close gaps in maternity services identified in their CDC Maternity

Practices in Infant Nutrition and Care reports.

For its second year, CDPHE invited hospitals to apply for a Colorado Can Do 5! B.E.S.T. (Breastfeeding Excellence

Starts Today) award by submitting copies of their breastfeeding policies for review. The Can Do 5! is a successful

initiative to move hospitals incrementally toward implementing the Baby-Friendly Ten Steps to Successful

Breastfeeding. Policies had to be inclusive of the five breastfeeding supportive practices of the Can Do 5! initiative

to be considered. Twenty hospitals received awards and public recognition at the hospital summit.

The Governor charged CDPHE with developing and implementing prevention strategies to reduce the prevalence

of obesity in Colorado. A strategy to impact Colorado's obesity epidemic is to increase breastfeeding at six and 12

months. Formula feeding is associated with higher risk for childhood obesity. CDPHE prioritized ensuring Baby-

Friendly hospitals as a strategy to support exclusive breastfeeding. A Baby-Friendly Hospital Advisory Committee

was convened to inform the planning process for this five to seven year project.

Colorado hospitals are engaged in improving hospital-based breastfeeding support services. Data comparisons

between 2008 and 2011 show continuing improvement in the practices of the Can Do 5! initiative.

breastfed infants, "Baby roomed in with mother" increased from 89.4 percent in 2008 to 91.9 percent in 2011,

"Staff gave mother a telephone number to call" increased from 85.7 percent in 2008 to 88.4

percent in 2011,

"Baby was fed only breast milk in the hospital" increased significantly from 54.6 percent in 2008 to 64.3 percent in

2011, "Baby was breastfed in the first hour" increased significantly from 67.0 percent in 2008 to 79.3 percent in

2011, and "Baby did not use pacifier in hospital" increased from 34.4 percent in 2008 to 39.1 percent in 2011.

Staff from CDPHE and the state Medicaid program collaborated on several activities as a means to improve

breastfeeding promotion and support for mothers. CDPHE prepared a fact sheet describing the role of

breastfeeding in reducing childhood risk of obesity and provided documentation and references for how hospitals

that provide optimal breastfeeding support can reduce health care expenditures (see NPM 14).

The Colorado Breastfeeding Coalition identified and worked with over 10 employers in various sectors to

showcase in a national database their efforts to accommodate nursing mothers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
Host Colorado Hospital Breastfeeding Summit		Х		Х
2. Awarded hospitals implementing five specific breastfeeding supportive practices				Х
3. Highlighted over 10 employers for a national database to support employers with accommodating nursing mothers		Х	Х	Х
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2013 is 60.0 percent.

A Baby-Friendly Hospital Advisory Committee meets quarterly to increase the number of Baby-Friendly facilities from

three to 18. This included: two webinars to inform hospital leadership on the business case for pursuing Baby-

Friendly designation and to provide information about the Colorado Baby-Friendly Hospital Collaborative;

developing and implementing a process to ensure enrollees meet selection criteria (e.g., demonstrated buy-in,

designated multi-disciplinary team); collecting baseline data; and assessing technical assistance needs.

For its final year, CDPHE invited remaining hospitals to apply for a Colorado Can Do 5! B.E.S.T. award. Eight hospitals

received awards and public recognition at the July Colorado Perinatal Care Council meeting.

Over 75 percent of

Colorado hospitals, representing over 89 percent of Colorado births, have received this award demonstrating a

commitment to improving breastfeeding practices.

The WIC and MCH Programs held a three-day lactation management training for 140 public health staff.

To improve the experiences of breastfeeding mothers using child care, CDPHE established and disseminated

standards for breastfeeding support in child care settings.

At least three local public health agencies and the Colorado Breastfeeding Coalition are working with employers in

their communities and statewide to ensure compliance with state and federal lactation accommodation laws.

c. Plan for the Coming Year

The target for reporting year 2014 is 60.0 percent.

CDPHE will augment efforts to strengthen local WIC agencies' ability to provide optimal breastfeeding support to

WIC breastfeeding families. CDPHE will ensure WIC Program staff develop local breastfeeding policy and follow state

level program policies regarding the provision of breastfeeding support and referrals; limited provision of formula to

breastfeeding infants; and partnering with organizations in the community to ensure continuity of lactation support

services for mothers upon discharge from the hospital.

Hospitals participating in the Colorado Baby-Friendly Hospital Collaborative will participate in three learning session

webinars and one workshop to address challenges while moving through the path to becoming Baby-Friendly.

CDPHE will allocate financial resources to offset hospital stated barriers (e.g., process fees, staff training, prenatal

and postpartum supportive services) to the Baby-Friendly process. CDPHE will increase opportunities for staff

education on the management of lactation and the Ten Steps to Successful Breastfeeding, through access to a 20-

hour online course.

To understand Colorado child care directors' and providers' professional development needs with regard to

breastfeeding support, CDPHE will complete a gaps analysis of their knowledge, attitudes and skills.

Performance Measure 12: Percentage of newborns who have been screened for hearing before hospital discharge.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

[3ecs 403 (2)(2)(D)(III) and 400 (a)(2)(A)(III)]							
Annual Objective and	2008	2009	2010	2011	2012		

Performance Data					
Annual Performance	98	98	98	98	98
Objective					
Annual Indicator	97.2	97.8	97.3	97.3	97.8
Numerator	68088	67905	66460	64265	63382
Denominator	70082	69432	68310	66066	64779
Data Source	Newborn Hearing Screening Program	Newborn Hearing Screening Program	Newborn Hearing Screening Program	Newborn Hearing Screening Program	Newborn Hearing Screening Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
or rinar:	2013	2014	2015	2016	2017
Annual Performance Objective	98	98	98	98	98

Notes - 2012

Data shown for reporting year 2012 are calendar year 2011 births.

The numerator is the number of newborns, born to Colorado residents who delivered in Colorado, that underwent newborn hearing screening at birth. The denominator is the number of live births to Colorado residents who gave birth in Colorado. (The denominator is smaller than the total number of births to Colorado residents by the number of residents who gave birth out of state.)

Notes - 2011

Data shown for reporting year 2011 are calendar year 2010 births.

The numerator is the number of newborns, born to Colorado residents who delivered in Colorado, that underwent newborn hearing screening at birth. The denominator is the number of live births to Colorado residents who gave birth in Colorado. (The denominator is smaller than the total number of births to Colorado residents by the number of residents who gave birth out of state.)

Notes - 2010

Data shown for reporting year 2010 are calendar year 2009 data.

The numerator is the number of newborns, born to Colorado residents who delivered in Colorado, that underwent newborn hearing screening at birth. The denominator is the number of live births to Colorado residents who gave birth in Colorado. (The denominator is smaller than the total number of births to Colorado residents by the number of residents who gave birth out of state.)

a. Last Year's Accomplishments

The indicator for reporting year 2012 showed that 97.8 percent of newborns were screened for hearing before

hospital discharge. The target for reporting year 2012 was 98.0 percent and it was not quite met.

CDPHE worked with other state agencies and partners to support comprehensive systems from screening through

early intervention at both the state and local level. The local Early Hearing Detection and Intervention (EHDI) teams

are comprised of hospital coordinators, local Audiology Regional Coordinators, Hands & Voices Parent Guides,

Colorado Hearing Resource Coordinators (CO-Hears), Part C Coordinators, Health Care Program for Children with

Special Health Care Needs (HCP) nurses and other stakeholders (physicians, audiologists). The local EHDI teams

continue to meet to address barriers in the EHDI system such as follow-up, travel to pediatric specialists and costs

of services. In addition, the local EHDI teams have utilized the lessons learned from Colorado's National Initiative in

Child Health Quality (NICHQ) project, such as scheduling the outpatient rescreen appointment prior to hospital

discharge to improve follow up.

Funding provided by the Association of University Centers on Disabilities (AUCD) Leadership in Neurodevelopment

and Related Disabilities (LEND), has increased the number of pediatric audiology sites from 12 to 15. The EHDI

program has partnered with the Marion Downs Hearing Center (MDHC) to provide intensive training to fourth-year

audiology doctoral students and rural audiologists who have the desire and equipment to test young infants.

Training for rural audiologists is provided in a variety of ways. Pediatric audiologists from the MDHC travel to the

audiologists' rural sites, the audiologists travel to Denver, and telehealth technology is used for ongoing monitoring

of evaluation and counseling. Funding from the Mountain States Regional Genetic Collaborative Center was used to

develop the opportunities to provide genetic counseling to families outside of the Denver metropolitan area.

The state Part C program has determined that children with unilateral and mild hearing loss are not eligible for

services unless the child exhibits a delay. As a result, CO-Hears do not have funding to serve these children. MCHB

EHDI funding supports a CO-Hear Coordinator to provide information to the family and also encourage them to

participate in the FAMILY assessment at the University of Colorado to monitor for any potential developmental delays.

Through CDC EHDI funds, all hospital coordinators have been trained to enter any missed or follow-up rescreen

results directly into the EHDI Integrated Data System (IDS). Newborn Hearing Hospital Coordinators have

successfully entered results on a monthly basis establishing more accurate and "real time" data. The Colorado Infant Hearing Advisory Committee (CIHAC): Chaired by Dr. Albert Mehl, continued to identify

opportunities to educate primary care providers on their role in the follow-up of infants who miss or fail a newborn

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service					
	DHC	ES	PBS	IB		
Increased number of pediatric audiologists through LEND program				Х		
Trained pediatric audiologists to enter data into IDS				Х		
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

b. Current Activities

The target for reporting year 2013 is 98.0 percent.

CDPHE staff continues to provide training for pediatric diagnosing audiologists to enter diagnostic information

directly into the Early Hearing Detection & Intervention Integrated Data System (EHDI IDS).

The Colorado Infant Hearing Program (IHP) staff and partners continue to investigate how to increase hearing

screenings for underserved populations, through education and access to free or lost cost screens. In addition, the

IHP staff is working with Early Head Start, Parents as Teachers, and plans to work with home visiting programs to

increase education to providers and access to otoacoustic emissions screening.

In April 2013, legislation passed that removed the sunset review of the state's infant hearing advisory committee

(CIHAC) from the infant hearing screening statute. CIHAC updated the Guidelines for Infant Hearing Screening,

Audiologic Assessment, and Early Intervention.

Newborn hearing screening results were added to the Colorado Immunization Information System (CIIS) to give

providers access to screening results. Selected primary care sites are piloting the program and offering feedback to

prepare statewide use.

Funding continues to be provided by the Association of University Centers on Disabilities (AUCD) Leadership in

Neurodevelopment and Related Disabilities (LEND), to increase the number of pediatric audiology sites. A survey is

being disseminated to identify audiologists who want additional training.

c. Plan for the Coming Year

The target for reporting year 2014 is 98.0 percent.

An audiology doctoral student from the University of Colorado completed a survey on how states fund EHDI

programs. With cuts to the MCH block grant and HRSA EHDI grants, the state EHDI programs need to develop a

sustainable system. Currently, 23 percent of respondents increased their newborn screening fee to support EHDI

programs. Colorado will convene members of the Advisory Committee to develop a sustainability plan.

In order to increase the screening rate for infants born at home, midwives who provide screening will be

given training and permission to enter results directly into the EHDI IDS. Education materials will be disseminated to

all midwives that include the Loss & Found DVD, a letter from a midwife who provides screening, a letter from a

parent whose child born at home was late identified, and resource information about where to obtain a screen.

Four additional screening units were obtained and will be placed in regions with a lower home birth screening

rate. Training will be provided for those individuals or sites.

Colorado will continue to promote parent support for families with children who are deaf and hard of hearing

through Colorado Hands & Voices. Hands & Voices is a key partner in increasing the screening follow-up through

customized Roadmap for Families (which serves as a referral guide for providers and families when an infant does

not pass a hearing screen) provided to every birthing hospital. Existing Roadmaps are being revised and updated.

Any hospitals that do not have a Roadmap will have one completed. The Loss & Found DVD will be distributed to

every birthing hospital to encourage families to follow-up after a failed screen.

Currently, 80 percent of the state's pediatric diagnosing audiologists are trained to directly enter electronic

audiology assessment reports in the EHDI IDS. CDPHE Infant Hearing Program will continue to provide training so

that all pediatric diagnosing audiologists are trained. By establishing a "real-time" data entry point for all stages of

the EHDI 1-3-6 Model (Screening by one month, Evaluation by three months, and Intervention by six months) with

birthing hospitals, diagnosing audiologists and interventionists entering data directly, the Colorado EHDI data

system will enhance processes and protocols at all levels of service to families with an increased ability to

communicate with professionals.

With the addition of the newborn hearing screening results to the CIIS, training and monitoring of data to primary

care providers will be needed for quality assurance. Approximately 80 percent of Colorado medical providers who

provide care to children will use the CIIS to obtain newborn hearing screening results which will increase

the follow-up rates for infants who do not pass the initial screening. The CDPHE Infant Hearing Program will provide education and training to primary care providers using the CIIS.

Performance Measure 13: Percent of children without health insurance.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)] Annual Objective and	2008	2009	2010	2011	2012
Performance Data			=515		
Annual Performance	10	8	8	5	10
Objective					
Annual Indicator	8.2	8.7	5.1	10.8	10.3
Numerator					
Denominator					
Data Source	Colorado Child Health Survey	Colorado Child Health Survey	Colorado Child Health Survey	Colorado Child Health Survey	Colorado Child Health Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	10	9.5	9	8.5	8

Notes - 2012

Data shown for reporting year 2012 are calendar year 2012 Colorado Child Health Survey results. The percentage includes children ages 1-14 uninsured at the time of the survey.

Estimates from RY2010 and earlier are not comparable to estimates from more current reporting years due to methodological changes.

Notes - 2011

Data shown for reporting year 2011 are calendar year 2011 Colorado Child Health Survey results. The percentage includes children ages 1-14 uninsured at the time of the survey.

The 2011 Child Health Survey results reflect changes to sampling and weighting methodology based on the 2011 BRFSS changes, therefore annual indicators prior to reporting year 2011 should not be compared to the reporting year 2011 annual indicator.

Notes - 2010

Data shown for reporting year 2010 are calendar year 2010 Colorado Child Health Survey results. The percentage includes children ages 1-14 uninsured at the time of the survey.

a. Last Year's Accomplishments

The indicator for reporting year 2012 showed that 10.3 percent of children had no health insurance. The target for

reporting year 2012 was 10.0 percent, and the target was not met.

The Medical Home MCH Implementation Team created state and local logic models and action plans to identify

systems building strategies to reduce barriers to a medical home approach for all children and youth, including those

with special health care needs. The following four strategies for systems building serve as foundations for the state

and local logic models and action plans and reflect the public health role in reducing barriers to a medical home

approach:

- Mobilize partnerships to support the coordination of medical home projects and initiatives
- 2. Develop and implement a medical home policy agenda
- 3. Develop and implement a plan for a community-based network of consumer voices
- 4. Facilitate support for providers to implement a medical home approach within their practices

CDPHE continued to coordinate and lead the Colorado Medical Home Initiative (CMHI), in partnership with HCPF. To

support the initiative, staff from the Children, Youth and Families Branch coordinated and facilitated the Colorado

Medical Home Community Forum and the Medical Home Coalition. The bi-monthly community forum consists of state

and local stakeholders and the coalition, which meets monthly, consists of representatives who are responsible for

statewide medical home projects or initiatives. The purpose of the community forum is to provide an opportunity for

state and local stakeholders to discuss and provide input on medical home current events in Colorado. The purpose

of the coalition is to strategically align the myriad of statewide medical home projects and initiatives for maximum

impact.

During the 2010-2011 session, the Colorado legislature passed Senate Bill 200 to create a nonprofit unincorporated

public entity known as the Colorado Health Benefit Exchange (COHBE). The bill also established a "Legislative Health

Benefit Exchange Implementation Review Committee" to provide oversight of the exchange. While CDPHE has not

been designated as one of the non-voting state agency participants on the Health Benefit Exchange, MCH staff has

closely tracked the development of the Exchange including participation on advisory committees that ensure access

for children throughout the state.

Table 4a. National Performance Measures Summary Sheet

Activities		Pyramid Level of Service					
	DHC	ES	PBS	IB			
1. Co-led the Colorado Medical Home Initiative, in partnership				Х			
with the Department of Health Care Policy and Financing							
2. Coordinated the MCH Implementation Team for the MCH				Х			
Medical Home Priority							

3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

b. Current Activities

The target for reporting year 2013 is 10.0 percent.

The Health Systems Unit (HSU) was created within the Prevention Services Division to serve as a centralized

mechanism for addressing issues related to health care and insurance. HSU staff participates on the MIT for the

medical home priority. The HSU is leading the development of a medical home policy agenda, an objective in the

medical home state action plan.

CDPHE continues to provide leadership for CMHI, in partnership with HCPF.

COHBE is building a statewide infrastructure to support its mission. COHBE issued awards in the spring of 2013 to

community-based organizations to provide local, in-person help using Colorado's new online marketplace for health

plans. Training and certification of these community-based assistance sites will occur during the summer with

implementation in the fall. Beginning in October, COHBE will transition to a new name, Connect for Health Colorado.

and the community-based assistance sites will be launched as the Connect for Health Assistance Network.

MCH staff continues to collaborate with ACA implementation efforts including involvement in streamlining the

movement between Connect for Health/COHBE and PEAK, the state's online application for health and human

service benefits, including Medicaid. By streamlining the movement between these systems MCH is helping to

minimize churn and maximize children's enrollment in both public and private health coverage.

c. Plan for the Coming Year

The target for reporting year 2014 is 9.5 percent.

Activities will continue for the upcoming year, with the Health Systems Unit staff becoming more involved in

monitoring this performance measure and interacting with Medicaid and other benefit plans with a focus on the MCH

population. Among other efforts, the Health Systems Unit staff will be completing and implementing strategies to

support a policy agenda to reduce barriers to coverage and care for children and youth. The Unit is also writing a

white paper on population health approach to the ACA to outline how public health will play a

Performance Measure 14: Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)	2)(A)(iii)]			
Annual Objective	2008	2009	2010	2011
and Performance				
Data				

Annual Objective and Performance	2008	2009	2010	2011	2012
Data					
Annual Performance Objective	24	23	23	23	23
Annual Indicator	24.3	23.5	23.2	24.2	22.9
Numerator	9825	12139	12132	6662	7688
Denominator	40432	51659	52292	27529	33627
Data Source	2007 Pediatric Nutrition Surveillance	2009 Pediatric Nutrition Surveillance	2010 Pediatric Nutrition Surveillance	2011 Pediatric Nutrition Surveillance	2012 WIC PC File
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.				Final	Final
Provisional or Final?				rifiai	rinai
	2013	2014	2015	2016	2017
Annual Performance Objective	22.7	22.5	22.2	22	21.8

Notes - 2012

Data shown for reporting year 2012 are from the April 2012 WIC Participant Characteristics (PC) file. CDC no longer produces the Pediatric Nutrition Surveillance System, so a new methodology had to be implemented to assess this indicator.

Estimates from RY2011 and earlier are not comparable to estimates from more current reporting years due to methodological changes.

Notes - 2011

Data shown for reporting year 2011 are from the 2011 Pediatric Nutrition Survey. The WIC program changed computer systems in the middle of the year, thus the 2011 annual indicator represents data collected from September through December 2011.

Notes - 2010

Data shown for reporting year 2010 are from the 2010 Pediatric Nutrition Survey.

a. Last Year's Accomplishments

The indicator for reporting year 2012 showed that 22.9 percent of children ages 2 to 5 years receiving WIC

services had a BMI at or above the 85th percentile. The target for reporting year 2012 was 23.0 percent,

however, due to methodological changes in the data analysis, the indicator cannot be compared to the target.

Future targets will be set based on results from the updated methodology.

During reporting year 2012, the Early Childhood Obesity Prevention (ECOP) MCH Implementation Team developed

state and local logic models and action plans. Fifteen local public health agencies selected early childhood obesity

prevention as a priority, seven of which will implement some of all of the strategies of the local action plan during

reporting year 2013. The ECOP team at CDPHE began implementation of the state action plan, which includes

strategies related to the public health, health care, and early care and education sectors with a focus on obesity

prevention during the preconception, prenatal, and early childhood periods.

A health care systems and public health collaborative convened to inform an obesity prevention message testing

project including messages targeting women between pregnancies (see SPM 2), pregnant women (see SPM 6).

and families of young children. The project involved eight focus groups of low income mothers, fathers.

grandparents, and pregnant women and key informant interviews of health care providers. The collaborative also

advised a professional development needs assessment of health professionals related to prepregnancy (see

SPM 2), prenatal (see SPM 6), and early childhood obesity prevention. This needs assessment informed activities

in reporting year 2013. Work related to implementing systems changes among health care organizations

participating in the collaborative were discontinued shortly after reporting year 2012 due to limited resources to

convene the group regularly.

The CDPHE and state Medicaid staff collaborated on the development of a childhood obesity prevention toolkit,

including clinical screening, treatment, and prevention guidelines and counseling tools pertaining to appropriate

weight gain during pregnancy (see SPM 6), breastfeeding (see NPM 11), and overweight and obesity in early and

late childhood.

Colorado WIC completed a three-year plan to enhance obesity prevention efforts for WIC families and began

implementation of year one activities. WIC staff contributed to the health care systems and public health

collaborative, the message testing project advisory, and the preconception health advisory. The state WIC staff

implemented an early childhood obesity prevention component to the WIC local agency nutrition education

planning process, and all local WIC agencies submitted plans for at least one evidence-based early childhood

obesity prevention strategy for implementation during the 2013 reporting year.

The Colorado Child and Adult Care Food Program (CACFP) applied for and received private foundation funding to

support implementation activities for the CACFP Healthier Meals Initiative. This effort aims to support child care

providers in serving meals that meet higher standards, by reducing barriers experienced by Colorado providers,

and by offering culinary training and menu planning tools. The ECOP team completed a literature review of obesity

prevention strategies in childcare settings, later used to prioritize agency-wide obesity prevention efforts. Two

MCH strategies for early childhood obesity prevention, the CACFP Healthier Meals Initiative and physical activity

training for child care providers were identified as CDPHE Obesity Integration Project strategies.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			vice
	DHC	ES	PBS	IB
Developed state and local logic models and selected local				Х
public health agency strategy				
2. Completed message testing			Х	
3. Completed ECOP professional development needs				Χ
assessment				
4. Created Medicaid childhood obesity prevention toolkit		Χ	Х	
5. Completed WIC ECOP activities	Х	Х	Х	Х
6. Implemented CACFP Healthier Meals Initiative			Х	Х
7. Completed ECOP child care literature review and CDPHE				Х
obesity planning				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2013 is 22.7 percent.

Seven LPHAS are implementing food access, messaging, child care, and work sites strategies. The ECOP team

offered tools, training, and learning circles. These agencies contributed to a work group that revised ECOP

messages tested in focus groups.

The ECOP Team compiled online clinical tools related to the prenatal, preconception, and early childhood periods, for

use by health professionals. WIC implemented automated World Health Organization growth charts to meet current

growth monitoring recommendations.

WIC began the Wellness Coordinator System pilot with ten LPHAs. Local wellness coordinators collaborated with

state WIC staff in obesity prevention training and implementation. WIC is also providing regional

trainings for local

staff focused on healthy weight promotion, counseling, and messaging.

Local WIC agencies are implementing strategies to increase healthy food access and physical activity for WIC

families and cooking and shopping courses. Others are engaged in the farm to family program, in which WIC families

use cash value vouchers for fruits and vegetables at farmers' markets.

The Colorado CACFP implemented new meal standards for child care providers. The ECOP team secured funding to

deliver the I am Moving, I am Learning training for local trainers and child care providers, and is engaged in activities

related to breastfeeding supportive practices in child care settings (see NPM 11).

c. Plan for the Coming Year

The target for reporting year 2014 is 22.5 percent.

The CDPHE ECOP Team will continue implementation of state action plans to prevent obesity in the preconception,

prenatal, and early childhood periods, including breastfeeding initiatives (see NPM 11). Colorado's local public health

agency MCH programs will also continue their ECOP action plans and collaboration with the CDPHE ECOP team. The

ECOP team will provide ongoing support to local public health agencies, especially in the area of messaging. In

partnership with state and local programs and agencies, and CDPHE's evaluation staff, the ECOP team will

implement an in-depth evaluation to assess the overall impact of the ECOP efforts across all components of the initiative.

Colorado WIC will complete the Wellness Coordinator pilot and invite additional local agencies to participate. WIC

will provide resources for local agencies to promote staff wellness, staff performance evaluation tools related to

ECOP, and implement online nutrition education with the primary focus on healthy eating and active living. Colorado

WIC will determine effective methods of ECOP messages delivery and create these channels for local WIC agencies.

WIC will continue the healthy weight promotion focus in local agency nutrition education plans and agencies will

continue existing ECOP nutrition plans or identify new strategies. In partnership with the Nutrition Services Delivery

Advisory, WIC will identify methods to enhance care of the post partum woman to promote a healthy weight prior to

the next pregnancy.

The Colorado CACFP will continue to support child care providers in meeting higher meals standards through training

and culinary workshops. The ECOP team will work with local organizations to identify partners to offer the CACFP

culinary curriculum in their areas. The ECOP team will continue to serve on the child care licensing rules revision

committee and quality rating improvement committees and will offer I am Moving, I am Learning trainings for trainers and CACFP participants.

The ECOP team will continue to build an inventory of statewide ECOP efforts and identify opportunities for collaboration among public health partners. The team will explore alignment between ECOP activities and the work

of the Health Systems Unit.

Performance Measure 15: Percentage of women who smoke in the last three months of pregnancy.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(T	T	T	1
Annual Objective	2008	2009	2010	2011	2012
and Performance					
Data				<u> </u>	
Annual	10	10	8	8.5	6.5
Performance					
Objective				<u> </u>	
Annual Indicator	10.8	8.1	9	6.5	6.1
Numerator					3969
Denominator					64980
Data Source	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System	Birth certificates	Birth certificates
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual	6	6	5.5	5.5	5

Notes - 2012

Performance Objective Data for reporting year 2012 are from 2011 births. Because of changes in how the question was asked in PRAMS, the birth certificate question is now used for reporting on this performance measure.

Colorado started using the revised birth certificate in 2007. The smoking question on the birth certificate asks for the number of cigarettes smoked per day during the three months before pregnancy, first three months, second three months, and the last three months of pregnancy.

Notes - 2011

Data for reporting year 2011 are from 2010 births. Because of the question change in PRAMS, the birth certificate question is used for reporting on this performance measure. Colorado started using the revised birth certificate in 2007. The smoking question on the birth certificate asks for the number of cigarettes smoked per day during the three months before pregnancy, first three months, second three months, and the last three months of pregnancy.

Notes - 2010

Data for reporting year 2010 are from 2009 Pregnancy Risk Assessment Monitoring System (PRAMS) data. In 2008 and earlier questionnaires, the smoking questions were only asked of women who smoked 100 or more cigarettes. In the 2009 questionnaire, the smoking questions were asked of women who smoked any amount of cigarettes.

a. Last Year's Accomplishments

The indicator for reporting year 2012 showed that 6.1 percent of women smoked during the last three months of

pregnancy. The target for reporting year 2012 was 6.5 percent and the target was met.

CDPHE worked with Health Care Policy and Financing (HCPF) to implement and track the new Medicaid tobacco

cessation counseling benefit during pregnancy and postpartum; worked towards implementing a 50 percent

administrative match for QuitLine services to Medicaid recipients; distributed and followed up on the tobacco tool kit

for Medicaid providers, including updates and provider feedback; and promoted QuitLine services with care

coordinators in seven Regional Care Collaborative Organizations (RCCOs), which were established by HCPF to

implement the Accountable Care Collaborative (ACC). The ACC is a care model recently implemented by the Medicaid

program to improve clients' health and reduce costs by changing the incentives and health care delivery processes

for providers from one that rewards a high volume of services to one that holds them accountable for health

outcomes.

The QuitLine pregnancy protocol, established in 2010 with American Recovery and Reinvestment Act grant funds,

continued to be offered with money from Colorado's voter-approved amendment 35 tobacco excise tax. The

specialized protocol includes a consistent coach across sessions; up to four more postpartum calls than the

standard five-call protocol; an incentive gift-card with funds added for each completed call; postpartum availability of

nicotine replacement therapy (NRT), even if NRT was used prenatally; and cessation-related text messaging support.

The Baby & Me Tobacco Free program offered free diapers for participating pregnant women

who stop smoking and

stay quit postpartum in 36 counties statewide. Since the program began in 2008, more than 2,000 pregnant

smokers have enrolled with 1,350 women who quit smoking by delivery. Of those who quit smoking, 59 percent and

43 percent remained tobacco-free at three- and six-months postpartum, respectively. Funding for the program

ended in July 2012, however some communities elected to continue the program with other funding sources.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			vice
	DHC	ES	PBS	IB
1. Collaborated with HCPF on various tobacco cessation benefits				Х
and resources				
2. Offered QuitLine protocol for pregnant and postpartum women		Х		
3. Baby & Me Tobacco Free program provided diaper vouchers	Х	Х		
for pregnant women who quit smoking				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2013 is 6.0 percent.

The QuitLine pregnancy protocol continues to be offered to pregnant and postpartum women. Efforts to promote the

QuitLine services with care coordinators in the Regional Care Collaborative Organizations (RCCOs) continue.

Maternal Wellness and tobacco cessation staff members are working with HCPF to further promote the Medicaid

tobacco cessation counseling benefit during pregnancy and postpartum as there has been low utilization of this

benefit by the provider community. The tobacco cessation staff members provide updates and feedback as needed

on the tobacco tool kit for Medicaid providers.

The Community Epidemiology, Planning and Evaluation Program at the University of Colorado Cancer Center is

conducting an evaluation of the Baby and Me Tobacco Free program with funding from the Amendment 35 grant. The

evaluation of four local programs that are implementing the curriculum will add to the body of knowledge about the

effectiveness of the program, as it has not been demonstrated to be evidence-based, but rather a promising practice.

c. Plan for the Coming Year

The target for reporting year 2014 is 6.0 percent.

Tobacco staff members will continue to work with HCPF to implement the 50 percent administrative match for

QuitLine services to Medicaid recipients. Staff members will also pursue implementation of the Medicaid over-the-

counter benefit, including NRT, authorized through Senate Bill 117 in 2010.

Other activities stated above will continue from the previous year.

Performance Measure 16: The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

Tracking Performance Measures

I racking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]						
Annual Objective and	2008	2009	2010	2011	2012	
Performance Data						
Annual Performance	10.5	9.5	9.5	11	9	
Objective						
Annual Indicator	9.5	12.4	13.5	11.5	12.3	
Numerator	34	45	49	39	43	
Denominator	358249	363012	362423	339475	349522	
Data Source	Death	Death	Death	Death	Death	
	certificates	certificates	certificates	certificates	certificates	
Check this box if you						
cannot report the						
numerator because						
1.There are fewer than 5						
events over the last year,						
and						
2.The average number of						
events over the last 3						
years is fewer than 5 and therefore a 3-year moving						
average cannot be applied.						
Is the Data Provisional or				Final	Final	
Final?				illai	i iliai	
i iidi.	2013	2014	2015	2016	2017	
Annual Performance	9	8.5	8	7.5	7	
Objective		0.0		,	,	

Notes - 2012

Data shown for reporting year 2012 are calendar year 2011 deaths. The data were retrieved from the Colorado Health Information Dataset (CoHID) at

http://www.chd.dphe.state.co.us/cohid/Default.aspx. The objectives were increased slightly to accommodate fluctuation in this rate.

Notes - 2011

Data shown for reporting year 2011 are calendar year 2010 deaths. The data were retrieved from the Colorado Health Information Dataset (CoHID) at

http://www.chd.dphe.state.co.us/cohid/Default.aspx. The objectives were increased slightly to accommodate fluctuation in this rate.

Notes - 2010

Data shown for reporting year 2010 are calendar year 2009 data representing suicide deaths for youth ages 15 through 19. The data were retrieved from the Colorado Health Information Dataset (CoHID) at http://www.cdphe.state.co.us/cohid/. Since the suicide rate fluctuates annually, only the annual performance objective for 2011 was changed.

a. Last Year's Accomplishments

The indicator for reporting year 2012 showed that there were 12.3 suicide deaths per 100,000 youth aged 15 to 19.

The target for reporting year 2012 was 9.0 per 100,000 and the target was not met.

Suicide remained the second leading cause of death among youth ages 10 through 24 in Colorado. Based on death

certificate data from 2002-2011, the ten-year annual average suicide rate for young adults ages 15-19 in Colorado

was 12.3 per 100,000, significantly higher than the Healthy People 2020 goal of 10.2 per 100,000 for all ages.

State funding of \$384,000 was allocated for suicide prevention programs statewide. In October 2009, the Office of

Suicide Prevention was awarded three years of funding from the Substance Abuse and Mental Health Services

Administration to continue and expand Project Safety Net. Eight community agencies that serve twenty counties

trained adults to recognize and intervene with suicidal youth, and to refer those youth to appropriate services.

Project Safety Net targeted adults who work with Latino youth, lesbian, gay, bisexual, transgender and questioning

youth, and youth in the juvenile justice and child welfare systems, all of which are at an elevated risk for suicide.

Project Safety Net also included a youth suicide prevention awareness campaign entitled Start the Conversation.

Posters, stickers, informational brochures, and a thirty second radio spot were disseminated statewide in English

and Spanish.

Other activities accomplished included ensuring that the suicide hotline (1.800.273.TALK) was operational 24 hours

per day, every day; providing more than 15,000 pieces of public awareness materials statewide; disseminating

community grants dedicated to suicide prevention across the state; working with the Suicide Prevention Coalition of

Colorado; and participating on key advisory boards like the Colorado School Safety Resource Center and Safe2Tell.

The Office of Suicide Prevention also sponsors and partners on the planning of the annual Bridging the Divide:

Suicide Awareness and Prevention Summit, which is attended by an average of 200 individuals from Colorado and

surrounding states.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service					
	DHC	ES	PBS	IB		

Trained adults to recognize and intervene with suicidal youth and refer those youth to appropriate services	Х	Х		
2. Youth suicide prevention awareness materials including posters, stickers, informational brochures and thirty second radio spot were disseminated statewide in English and Spanish		Х	Х	
3. Continued other activities within work plan to reduce suicide	Χ	X	X	Χ
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2013 is 9.0 deaths per 100,000.

The Office of Suicide Prevention partnered with the Colorado Department of Public Safety and the Colorado

Department of Education to plan and host a suicide prevention symposium for school personnel throughout

Colorado in November 2012. More than 150 school personnel attended the event in Aurora, CO, which focused on

suicide risk assessment, prevention programs in schools, and post-intervention (managing the school and

community after a suicide death). Other activities include ensuring that the suicide prevention Lifeline is operational

24 hours per day; disseminating community grants dedicated to suicide prevention across the state; working with

the Suicide Prevention Coalition of Colorado; and participating on key advisory boards.

Proposed state funding of \$384,000 was allocated for suicide prevention programs in April 2013. Activities included

planning and sponsoring the sixth annual Bridging the Divide: Suicide Awareness and Prevention Summit in Denver,

Colorado in May 2013.

c. Plan for the Coming Year

The target for reporting year 2014 is 8.5 deaths per 100,000.

Activities will continue from the previous year. Project Safety Net funding ended in September 2012, and the

Substance Abuse and Mental Health Services Administration did not release a new funding announcement under the

Garrett Lee Smith Memorial Act. The Office of Suicide Prevention anticipates a new funding announcement from

SAMHSA in January 2014.

Performance Measure 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2008	2009	2010	2011	2012
Performance Data					
Annual Performance Objective	85	83	85	82	89.5
Annual Indicator	80.5	82.7	80.5	89.2	90.6
Numerator	749	767	749	793	752
Denominator	930	928	930	889	830
Data Source	Birth certificates	Birth Certificates	Birth Certificates	Birth Certificates	Birth Certificates
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	91	91.5	91.5	92	92

Notes - 2012

Data shown for reporting year 2012 represent calendar year 2011 births. The denominator represents very low birth weight births to Colorado residents.

Notes - 2011

Data shown for reporting year 2011 represent calendar year 2010 births. The denominator represents very low birth weight births to Colorado residents.

Data reported in the previous four years of block grants (FY09-FY12) underestimated the actual values by about six percentage points due to misclassification of one hospital. This error has been corrected for reporting year 2011. The percentage for reporting year 2011 of 89.2 reflects the corrected list of facilities for high risk delivery and neonates.

Notes - 2010

Data shown for reporting year 2010 represent calendar year 2009 data. The denominator represents very low birth weight births to Colorado residents.

a. Last Year's Accomplishments

The indicator for reporting year 2012 showed that 90.6 percent of very low birth weight infants were delivered at

hospitals for high-risk deliveries and neonates. The target for reporting year 2012 was 89.5 percentand the target

was met.

The Colorado Perinatal Care Council (CPCC) is a volunteer, non-profit advisory group whose members represent the

majority of birthing hospitals in Colorado including a variety of professions and organizations with

an expertise or

interest in perinatal care. The Council conducts self-assessments related to hospital designation of obstetric and

neonatal care levels. Last year, the Council's work mainly focused on decreasing elective deliveries without medical

indication, addressing antenatal steroid use, promoting exclusive breast milk feeding and decreasing central line

associated bloodstream infections in newborns (CLABSI). The Council also committed to partnering with staff from

the Health Care Program for Children with Special Needs (HCP) to improve the transition and referral process of

neonatal intensive care unit (NICU) babies.

A Maternal Wellness staff member participates on the CPCC, shares related information, and collaborates with other members.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			vice
	DHC	ES	PBS	IB
Self-assessed CPCC member Level I-III designations				Х
2. Decreased elective deliveries without medical indication				Х
3. Addressed antenatal steroid use				Χ
4. Promoted exclusive breast milk feeding				Х
5. Decreased central line associated bloodstream infections				Х
6. Supported CDPHE efforts to address NICU baby transition				Х
and referral processes				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2013 is 91.0 percent.

The CPCC continues to monitor hospital perinatal levels of care designations. The CPCC is reviewing the new Level IV designation.

A Maternal Wellness staff member continues to participate on the CPCC.

c. Plan for the Coming Year

The target for reporting year 2014 is 91.5 percent.

Activities will continue from the previous year. The CPCC will begin to conduct self-assessments in alignment with

the new Level I-IV criterion.

A Maternal Wellness staff member will continue to participate on the CPCC.

Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2008	2009	2010	2011	2012
Performance Data					
Annual Performance	84	82	77	78	79.5
Objective					
Annual Indicator	78.1	76.9	77.7	79.0	79.4
Numerator	53828	52298	52185	51457	50313
Denominator	68957	67985	67167	65114	63384
Data Source	Birth	Birth	Birth	Birth	Birth
	certificates	certificates	certificates	certificates	certificates
Check this box if you					
cannot report the numerator					
because					
1.There are fewer than 5					
events over the last year,					
and					
2.The average number of					
events over the last 3 years					
is fewer than 5 and					
therefore a 3-year moving					
average cannot be applied. Is the Data Provisional or				Final	Final
Final?				Filiai	Filiai
rillal!	2013	2014	2015	2016	2017
Annual Performance	80		81		82
Objective	00	80.5	01	81.5	02

Notes - 2012

Data shown for reporting year 2012 are calendar year 2011 births. The number of pregnant women whose onset of prenatal care is unknown have been excluded. Data were obtained from the Colorado Health Information Dataset (CoHID) at

http://www.chd.dphe.state.co.http://www.chd.dphe.state.co.us/cohid/Default.aspx.us/cohid/Default.aspx.

Notes - 2011

Data shown for reporting year 2011 are calendar year 2010 births. The number of pregnant women whose onset of prenatal care is unknown have been excluded. Data were obtained from the Colorado Health Information Dataset (CoHID) at

http://www.chd.dphe.state.cohttp://www.chd.dphe.state.co.us/cohid/Default.aspx.us/cohid/Default.aspx.

Notes - 2010

Data shown for reporting year 2010 are calendar year 2009 data. The number of pregnant women whose onset of prenatal care is unknown have been excluded. Data were obtained from the Colorado Health Information Dataset (CoHID) at http://www.cdphe.state.co.us/cohid/index.html.

a. Last Year's Accomplishments

The indicator for reporting year 2012 showed that 79.4 percent of infants were born to pregnant women receiving

prenatal care beginning in the first trimester. The target for reporting year 2012 was 79.5 percent,

which was essentially met.

Maternal Wellness staff monitored activities of the Healthy Women Healthy Babies Access to Care Workgroup. The

Access to Care Workgroup was awarded a small grant from the Marquez Foundation focused on strengthening

comprehensive prenatal care, including decreasing cost and improving outcomes. Specifically, the workgroup

collaborated with local community partners to create pathways for implementation of wrap-around prenatal services

such as Nurse Family Partnership, Prenatal Plus and Centering Pregnancy models of care.

Access to care was included under the MCH priority to reduce barriers to a medical home approach. Activities under

this priority focus on population-based, system level change as led by a MCH Implementation Team (MIT) dedicated

to providing guidance and direction on implementation for this priority. The focus is on reducing barriers to care by

addressing local and statewide systems, with a specific emphasis on early childhood systems.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service				
	DHC	ES	PBS	IB	
1. Monitored activities of Healthy Women Healthy Babies Access				Х	
to Care Workgroup					
2. Implemented the Medical Home action plan				Х	
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

b. Current Activities

The target for reporting year 2013 is 80.0 percent.

In January 2013, the Healthy Women Healthy Babies Access to Care Workgroup completed a report as part of the

Marquez Foundation grant, which summarized recommendations for improved access to early and comprehensive

prenatal care. The group also connected with the Regional Care Collaborative Organizations to explore

opportunities for improving access to early and comprehensive prenatal care. The Healthy Women Healthy Babies

non-profit organization decided to disband in April 2013 and therefore the Access to Care subworkgroup has also

ended. The group maintains a listserv to continue to disseminate information about opportunities to advocate for

early and comprehensive prenatal care.

Additional systems-level activities to address access to care continue to be included in the medical home state action

plan. Local public health agencies with medical home action plans have focused efforts on early childhood in

alignment with existing early childhood systems building efforts (See NPM 3).

Additionally, the Colorado legislature approved expansion of Medicaid under the Affordable Care Act during the 2013

session. This will provide access to Medicaid benefits for all individuals below 133 percent of the federal poverty

level.

c. Plan for the Coming Year

The target for reporting year 2014 is 80.5 percent.

The Medicaid expansion is estimated to add anywhere from 240,000 -- 300,000 new enrollees in the program by

2025, most of whom are currently uninsured or under-insured. This will likely improve access to early prenatal care.

Maternal Wellness staff members will continue to monitor this measure as health care reform is implemented

starting in January 2014.

Implementation of the medical home state and local action plan will continue.

D. State Performance Measures

State Performance Measure 1: Percent of sexually active women and men ages 18-44 years using an effective method of birth control to prevent pregnancy.

Tracking Performance Measures

[Secs 485	(2)(2)(B)(iii)	and 486	(a)(2)(A)(iii)]
-	-	_	_	

Annual Objective and	2008	2009	2010	2011	2012
Performance Data					
Annual Performance Objective				73	74
Annual Indicator	74.4	68.6	72.2	73.3	61.8
Numerator					
Denominator					
Data Source	Behavioral Risk Factor Surveillance System				
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017

Annual	62.5	63	64	66	68
Performance					
Objective					

Notes - 2012

Data for reporting year 2012 represent 2011 data. The 2011 data reflect a number of methodological changes in the Behavioral Risk Factor Surveillance Systems Survey. The changes include the addition of surveys among cell phone users and the replacement of post-stratification weighting with a more advanced method called "iterative proportional fitting," also sometimes called "raking." Consequently, results for reporting year 2012 should not be directly compared with results in earlier years based on different methods.

Effective methods of birth control include tubes tied, vasectomy, hysterectomy, pill, contraceptive implants, shots (Depo-Provera, Lunelle), contraceptive patch, contraceptive ring, and IUD. Respondents who are pregnant or trying to get pregnant are excluded.

Notes - 2011

Data for reporting year 2011 represent 2010 data. Effective methods of birth control include tubes tied, vasectomy, hysterectomy, pill, contraceptive implants, shots (Depo-Provera, Lunelle), contraceptive patch, contraceptive ring, and IUD. Respondents who are pregnant or trying to get pregnant are excluded.

Notes - 2010

Data for reporting year 2010 represent 2009 data. Effective methods of birth control include tubes tied, vasectomy, hysterectomy, pill, contraceptive implants, shots (Depo-Provera, Lunelle), contraceptive patch, contraceptive ring, and IUD. Respondents who are pregnant or trying to get pregnant are excluded.

a. Last Year's Accomplishments

The indicator for reporting year 2012 showed that 61.8 percent of sexually active women and men ages 18-44

used an effective method of birth control to prevent pregnancy. The target for reporting year 2012 was 74.0

percent; however, due to methodological changes in the data analysis, the indicator cannot be compared to the

target. Future targets will be set based on results from the updated methodology.

The Colorado Title X Family Planning Program received funding for the Colorado Family Planning Initiative (CFPI) to

address unintended pregnancy (see report attached to III. State Overview A. Overview). Roughly \$5 million in

grant funds was used to increase access to family planning services. This included the purchase of long-acting,

reversible contraceptives (IUD's and Nexplanon) for use by 28 Title X clinics statewide. Between FY08 and FY12.

the annual number of long-acting reversible contraceptive (IUD and implant) patients in Title X clinics more than

quadrupled, from 2,275 in FY08 to 10,140 in FY12, increasing from 1 in 16 (6.3 percent) female contraceptors in

the program in FY08 to more than 1 in 5 (21.4 percent) in FY12.

CFPI funds were also used to build the income generation capacity at the clinics through investments in electronic

health records, clinic improvement assessments, hardware and software purchases, and billing and coding

training. These investments helped prepare Title X clinics for implementation of the Affordable

Care Act and

ensure access to services for the newly insured (private and Medicaid) population. The CFPI program held a

conference in August 2012 to help disseminate best practices.

CFPI partnered with Vermillion, Inc. to create a public awareness campaign, titled Beforeplay, focused on getting

women and men ages 18-29 to talk about their reproductive health, including using birth control and planning for

pregnancy. The campaign aims to normalize the conversation about sexual health and family planning through an

interactive website, use of social media, and statewide advertising both on and offline. The website

(www.beforeplay.org) encourages young adults to take control of and responsibility for their sexual health by

having conversations with their partners, friends, family and medical providers. It also features a Colorado health

care center finder that highlights publicly supported clinics, allowing young adults to identify sexual health and

family planning services, regardless of financial circumstances. The campaign launched in February 2012 and the

response has been overwhelmingly positive. The campaign also drew statewide and national media attention. As

of April 2013, the site had more than 200,000 unique visitors, and an estimated 500 unique visitors access the

site each day. The campaign also has more than 8,000 likes/fans on Facebook. The Preconception Health MIT

partnered with CFPI to help disseminate materials and information about the Beforeplay campaign to MCH partners.

Through a contract with HealthTeamWorks, the Maternal Wellness Team completed 12 Rapid Improvement

Activities (RIAs) and four additional presentations to professional health organizations on Colorado's

Preconception and Interconception Clinical Guideline and Contraceptive Guideline. The purpose of the RIAs is to

help clinics integrate guidelines into practice. Participants in the RIAs included medical doctors, mid-level staff and

other office staff; in total, 369 staff members received training on how to incorporate the guidelines into clinical

practice. An additional 125 health professionals were trained through attendance at one of the presentations.

The Family Planning client database was changed to incorporate data fields that capture preconception

care activities that occur during family planning visits. This change will facilitate improved reporting on Title X

activities. The Title X Family Planning manual was reviewed to ensure preconception concepts were adequately

covered and no further changes were required. Family Planning providers were surveyed about preconception

health knowledge, practice and barriers and this information will inform the design of future training

modules.

The Preconception Health Advisory Committee (PHAC), comprised of external stakeholders from various agencies

in Colorado, continued to meet quarterly to provide guidance to the state Maternal Wellness Team to help

advance activities related to this performance measure.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			/ice
	DHC	ES	PBS	IB
1. Began screening for SCID	Х			
2. Continued research to establish high-altitude-specific newborn pulse oximetry values	Х			
Participated in national meeting to define "case definitions and quality indicators"	Х	Х		
Uploaded newborn screening results into existing Immunization Registry	Х	Х		Х
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2013 is 62.5 percent.

The Family Planning Program continues to provide funding to promote the use of long-acting reversible

contraceptives, access to family planning services and infrastructure development at Title X clinics in preparation for

implementation of the Affordable Care Act.

CFPI continues to promote the Beforeplay campaign. Website content was translated into Spanish, including

testimonials from Spanish-speaking Coloradans regarding birth control, reproductive health, pregnancy planning and

starting the conversation. A media launch of the Spanish website occurred in early 2013.

A report of the formative evaluation of CDPHE's Reproductive Life Plan tool was completed and shared with other

partners working on preconception health initiatives nationally. The purpose of the report was to 1) capture results

from the process evaluation, 2) document the methods and challenges of the outcome evaluation, and 3) summarize

the feasibility of a paper-based preconception health tool.

The Preconception Health MIT completed a review of preconception health-related activities by completing a

community assessment, review of the data, and developing a statement of the issue. The community assessment

step included a survey of internal CDPHE programs to identify potential areas of collaboration, as well as a

brainstorm session with external stakeholders who participate on the PHAC.

c. Plan for the Coming Year

The target for reporting year 2014 is 63.0 percent.

CFPI and MCH staff will continue to promote the Beforeplay campaign.

Through the evidence-based public health process it was determined that activities for promoting preconception

health at a population health level were not currently available and additional MCH activities to promote intended

pregnancy beyond those stated through collaboration with the Title X Family Planning Program, CFPI and the

Beforeplay campaign will not be pursued.

In 2013-2014, limited CFPI funding will be provided to all Title X agencies to continue to promote the use of long-

acting reversible contraceptive methods and position Title X clinics to sustain themselves in the era of health care

reform by accessing new and increasing funding sources. Title X will continue to partner with 28 delegates statewide

to ensure family planning services for men and women. The goal is to provide quality, subsidized family planning

services to 60,000 clients, of which 89 percent will be at or below 150 percent of the federal poverty level. In

Colorado, the Connect for Health Colorado insurance marketplace and expanded Medicaid services (up to 133

percent of FPL) are due to launch in January 2014. Both CFPI and Title X staff will be watching the early impact of

both of these programs on the network of family planning clinics across the state.

State Performance Measure 2: Percent of live births to mothers who were overweight or obese based on BMI before pregnancy.

Tracking Performance Measures

Secs 485	(2)(2)(B)(iii)	and 486	(a)(2)(A)(iii)1

Annual Objective and	2008	2009	2010	2011	2012
Performance Data					
Annual Performance				35.5	43
Objective					
Annual Indicator	35.0	34.8	35.9	43.2	43.0
Numerator	22468	22770	23832	27885	27171
Denominator	64160	65385	66398	64520	63233
Data Source	Birth	Birth	Birth	Birth	Birth
	certificate	certificates	certificates	certificates	certificates
Is the Data Provisional				Final	Final
or Final?					
	2013	2014	2015	2016	2017
Annual Performance	42.5	42	41.5	41	40.5
Objective					

Notes - 2012

Data for reporting year 2012 represent calendar year 2011 births.

Data for reporting years 2011 and 2012 use the 2009 IOM BMI categories for weight gain during

pregnancy. Data for reporting years 2010 and earlier use the 1990 IOM BMI categories for weight gain during pregnancy. Thus, data for reporting year 2011 and 2012 are not comparable to data from earlier reporting years.

Notes - 2011

Data for reporting year 2011 represent calendar year 2010 births.

Data for reporting year 2011 use the 2009 IOM BMI categories for weight gain during pregnancy. Data for reporting years 2010 and earlier use the 1990 IOM BMI categories for weight gain during pregnancy. Thus, data for reporting year 2011 is not comparable to data from earlier reporting years.

Notes - 2010

Data for reporting year 2010 represent calendar year 2009 births.

a. Last Year's Accomplishments

The reporting year 2012 indicator showed that 43.0 percent of live births were to mothers who were overweight or

obese based on BMI before pregnancy. The reporting year 2012 target was 43.0 percent, which was met.

Through a contract with the Maternal Wellness Team, HealthTeamWorks completed 12 Rapid Improvement Activities

(RIAs) and four additional presentations to professional health organizations on Colorado's Preconception and

Interconception Clinical Guideline, which included the recommendation to attain or maintain a healthy body weight

prior to pregnancy (See SPM 1).

The Preconception Health Advisory Committee (PHAC) met quarterly to provide feedback and guidance on the state

preconception healthy weight strategies, objectives, and activities. In developing the action plans and logic models,

work related to healthy weight prior to conception was integrated into the early childhood obesity prevention efforts

and a Maternal Wellness staff member, as well as members of the PHAC with an interest in the healthy weight

component, joined the early childhood obesity prevention health care systems and public health collaborative and a

message testing advisory committee. These groups advised the testing of early childhood obesity prevention

messages with focus groups, including messages targeting the inter-conception period. Also, the Maternal Wellness

and Early Childhood Obesity Project (ECOP) teams collaborated to complete an early childhood obesity prevention

professional development needs assessment, including preconception components, which informed professional

development activities for health professionals in reporting year 2013 (See NPM 14).

Seven local public health agencies identified early childhood obesity prevention as a priority, which includes women

of reproductive age as a target population.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service		vice	
	DHC	ES	PBS	IB
Conducted Rapid Improvement Activities on Preconception				Х
and Interconception Clinical Guidelines				
2. Tested ECOP messages				Χ
3. Completed ECOP professional development needs				Χ
assessment				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2013 is 42.5 percent.

The ECOP MCH Implementation Team convened a stakeholder work group that revised obesity prevention messages

tested in the focus groups, including those targeting the interconception period, and informed statewide message

dissemination. The team compiled online early childhood obesity prevention clinical tools and prevention messaging

related to the life course approach for use by health professionals, including those relating to preconception healthy

weight (see NPM 14).

Local public health agencies implemented year one activities of the ECOP action plans, which target women of

reproductive age among other populations (see NPM 14). The ECOP team also completed an inventory of Colorado

early childhood obesity prevention efforts (including preconception healthy weight efforts), which will enable CDPHE

to promote local collaborative obesity efforts.

The Maternal Wellness Team collaborated with WIC to provide information and resources on postpartum weight loss

to promote interconception healthy weight for this year's WIC regional meetings held in August 2013. Focusing on

the mother's weight status postpartum is a new area for WIC practitioners, who traditionally shift education efforts

solely to the baby and breastfeeding during the postpartum period.

c. Plan for the Coming Year

The target for reporting year 2014 is 42.0 percent.

Preventing obesity requires multi-sector, collaborative approaches at state and local levels. The Maternal Wellness

Team will continue to work collaboratively with the ECOP Team to address childhood obesity, including preconception

healthy weight. Related strategies include promoting breastfeeding-friendly practices in child care settings,

supporting local public health agencies in implementing their ECOP local action plans, and identifying a reasonable

approach in WIC to enhance care of the postpartum woman to achieve a healthy weight prior to the next

pregnancy. The ECOP team will also continue to build the statewide inventory of ECOP efforts and will collaborate

with the Health Systems Unit to identify opportunities to advance preconception healthy weight efforts.

State Performance Measure 3: Percent of mothers reporting that a doctor, nurse, or other health care worker talked with them about what to do if they felt depressed during pregnancy or after delivery.

Tracking Performance Measures

		(a)(2)(A)(iii)]	

Annual Objective	2008	2009	2010	2011	2012
and Performance					
Data					
Annual				73	75.5
Performance					
Objective					
Annual Indicator			72.6	75.1	76.6
Numerator					
Denominator					
Data Source			Pregnancy Risk	Pregnancy Risk	Pregnancy Risk
			Assessment	Assessment	Assessment
			Monitoring System	Monitoring System	Monitoring System
Is the Data				Final	Final
Provisional or					
Final?					
	2013	2014	2015	2016	2017
Annual	77	78	79	80	81
Performance					
Objective					

Notes - 2012

Data for reporting year 2012 represent 2011 data.

Notes - 2011

Data for reporting year 2011 represent 2010 data.

Notes - 2010

Data for reporting year 2010 represent 2009 data.

a. Last Year's Accomplishments

The indicator for reporting year 2012 showed that 76.6 percent of mothers reported that a doctor, nurse, or other

health care worker talked with them about what to do if they felt depressed during pregnancy or after delivery.

The target for reporting year 2012 was 75.5 percent and the target was met.

The Maternal Wellness Team in collaboration with Epidemiology, Planning and Evaluation staff completed the

Brownson model pilot project and developed evidence-guided state and local county logic models

and three-year

action plans for pregnancy-related depression (PRD). In March 2012, local health agency logic models and action

plans were shared with local public health agency MCH staff during the Colorado MCH conference.

The state PRD Advisory Committee, which is comprised of 18 external stakeholders from various agencies in

Colorado, continued to meet quarterly. This committee provides feedback and guidance on the PRD work plan

strategies, objectives and activities.

A contractor for the Maternal Wellness Team conducted key informant interviews with 16 states that have

successfully implemented PRD initiatives to understand the strategies, successes and challenges from other

states.

These interviews helped guide the team's work and provided considerations for future initiatives in Colorado.

These

interviews helped identify four states that have secured Medicaid reimbursement for PRD screening; follow-up

interviews were conducted to identify innovative ways to pursue reimbursement for PRD screening of pregnant

and

postpartum women enrolled in Colorado Medicaid.

The Maternal Wellness Team partnered with Katherine Stone of Postpartum Progress, Inc. to conduct a webinar

on

PRD. This webinar provided an overview on the symptoms, screening and treatment of PRD and drew over 130

participants from across Colorado.

Two local public health agencies (LPHAs), Tri-County Health Department and Jefferson County Public Health.

conducted community needs assessment activities in their local work plans related to this priority prior to

development of the official local action plans, which began in October 2012. Tri-County conducted 13 key

informant

interviews with programs internal to the county health department, focus groups with 26 postpartum women,

and

an electronic survey was sent to over 175 community contacts who interact with women during pregnancy or

early

postpartum to assess screening and referral practices provided by these community members, as well as identify

future training needs. Jefferson County conducted four key informant interviews with various community

providers,

a client survey answered by 51 participants in JCPH programs and a health care provider survey answered by 36

providers. Tri-County will continue to work on this priority in the future. Jefferson County chose not to continue

this

activity in the coming year.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service				
	DHC	ES	PBS	IB	
Completed Brownson's model pilot portfolio project				Х	
2. Developed and shared logic model and work plan				Х	
3. Attended statewide Advisory Committee meetings				Х	
4. Conducted nationwide research on other state efforts				Х	
5. Held PRD webinar			Х		
6. Completed local public health agency community needs				Х	
assessments					
7.					
8.					
9.					
10.					

b. Current Activities

The target for reporting year 2013 is 77.0 percent.

The Maternal Wellness Team partnered with HealthTeamWorks (HTW) to develop clinical guidance on PRD to

supplement HTW's Adult Depression Guideline. This supplement focuses on what to do when a pregnant or

postpartum woman screens positive for depressive symptoms and the risks and benefits of medication use.

A statewide survey of programs and individuals who interact with pregnant and/or postpartum women was

conducted to identify current PRD screening processes and referral resources. The survey collected 584 responses

statewide and allowed for the mapping of strengths and gaps in the current referral system. A standard screening

tool is not used in many agencies and referral follow-up is often lacking. There is a gap in the diversity of referral

resources used, with most agencies relying on mental health agencies.

To better integrate the PRD efforts with prenatal substance abuse and early childhood efforts addressing social-

emotional screening and infant mental health, partnerships are being created or enhanced with others who are

reaching out to similar provider populations with messages around screening, identification and treatment for these

related issues. The intent is to avoid duplicative or conflicting outreach efforts.

Six LPHAs selected this priority. Tri-County and Larimer County are working to establish strong community partners

through participation in or development of a collaborative of key stakeholders.

c. Plan for the Coming Year

The target for reporting year 2014 is 78.0 percent.

The Maternal Wellness Team will build upon its partnership with HealthTeamWorks and implement the supplemental

PRD guidance developed. This implementation stage will include statewide technical assistance and capacity-building

activities. A committee of external stakeholders convened by HealthTeamWorks to assist in the development of the

guidance will also assist in shaping the design of these activities. The Maternal Wellness team will work with its

internal evaluators and/or an external agency to understand the impact of the guidance and its alignment with

other health reform requirements faced by health care agencies.

The Maternal Wellness Team will conduct information-sharing opportunities with local partners through Learning

Circles and other platforms. A Maternal Wellness summit will be held in late 2013 in partnership with nursing and

mid-level providers, a sector of health professionals who are more likely to have the time to address PRD with

patients. This summit will equip providers with the skills and tools needed to address pregnancyrelated depression

with their patients.

The Maternal Wellness Team will strengthen its work with Medicaid and Human Services collaborators through joint

committees, data sharing, integrated efforts and additional activities when applicable. The team will also continue to

integrate its work collaboratively with substance abuse and early childhood partners in the community. The PRD

Advisory Committee will continue to meet to achieve the objectives in the MCH state action plan.

State Performance Measure 4: Percent of parents asked by a health care provider to fill out a questionnaire about development, communication, or social behavior of their child ages 1 through 5.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				44	40
Annual Indicator	44.2	48.2	43.8	39.8	53
Numerator Denominator					
Data Source	Colorado Child Health Survey				
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance	53.5	54	54.5	55	56

Objective

Notes - 2012

Data for reporting year 2012 represent 2012 Colorado Child Health Survey results. The estimates for RY2011 and RY2012 are not statistically different.

Estimates from RY2010 and earlier are not comparable to estimates from more current reporting years due to methodological changes.

Notes - 2011

Data for reporting year 2011 represent 2011 Colorado Child Health Survey results.

The 2011 Child Health Survey results reflect changes to sampling and weighting methodology based on the 2011 BRFSS changes, therefore annual indicators prior to reporting year 2011 should not be compared to the reporting year 2011 annual indicator.

Notes - 2010

Data for reporting year 2010 represent 2010 Colorado Child Health Survey results.

a. Last Year's Accomplishments

The annual indicator for reporting year 2012 showed that 53.0 percent of parents were asked by a health care

provider to fill out a questionnaire about development, communication, or social behavior of their child ages one

through five. The target for reporting year 2012 was 40.0 percent and the target was met.

The work related to this performance measure was in partnership with the Assuring Better Child Health and

Development (ABCD) project. The current, three-year (2010-2012) strategic plan includes the goal of increasing the

number of practices/primary care providers using a standardized developmental screening tool.

Activities related to this goal included continued outreach to primary care providers who have not vet incorporated

the use of a standardized developmental screening tool into their practices. ABCD continued its partnership with the

Colorado Child Health Access Program (CCHAP) whose mission is to increase the number of Medicaid providers in

Colorado. All practices that work with CCHAP were referred to ABCD in the interest of including developmental

screening tools in quality improvement.

ABCD's outreach to physician's resulted in an increase in the number of practices using standardized developmental

screening tools. Of the approximately 700 practices with the potential to provide health care to young children

(pediatric and family medicine practices), 33 percent are now using standardized developmental screening tools, up

from 14 percent in 2010. Seventy (70) percent of pediatric practices use standardized developmental screening

tools, up from 54 percent in 2010.

Table 4b. State Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
Conducted outreach to primary care providers				Χ
2. Approved CME for ABCD training				Χ
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2013 is 53.5 percent.

An ABCD Continuing Medical Education (CME) event was offered for pediatric and family medicine providers. Specific

outreach and marketing was conducted to recruit those health care practices not currently using standardized

screening tools to screen children. Of those health care providers attending that were not currently screening, 100

percent have now implemented policies and procedures to support developmental screening and referral in their

practices.

A new practice level CME opportunity has been reviewed and approved in partnership with National Jewish Hospital

that awards a level 1 CME to health care providers who participate in a one-on-one training provided by ABCD

medical staff. ABCD also is providing training to medical and nursing students on the importance of developmental

screening and referral.

ABCD continued to build upon provider outreachand upon the partnership with CCHAP, ABCD established a baseline

of how many recruited practices are meeting the American Academy of Pediatrics guideline of three child screenings

by age three: about 90 percent met this guideline. ABCD has also focused on creating sustainability in communities

by sharing best practices on visit structure and messaging for provider outreach, and accompanying local

representatives to provider visits in order to model. While local data are not yet available, communities report

successfully recruiting some providers.

c. Plan for the Coming Year

The target for reporting year 2014 is 54.0 percent.

In the upcoming year, ABCD will continue to support practices in adopting the use of standardized screening tools

and continue to demonstrate a steady increase in the statewide measure. Currently, 44 percent of pediatric and

family practices, and 88 percent of pediatric practices are using a standardized tool.

ABCD will maintain and enhance state partnerships to support standardized developmental and social emotional

screening by identifying state and local partners to serve on the ABCD Board of Directors and develop an ABCD

business plan. Training and technical assistance will continue to be provided to support local efforts to develop a

referral roadmap with agreed upon roles and responsibilities in an ideal coordinated system of care for screening,

referral and follow-up as defined by an agreed upon community goal.

ABCD will continue to provide technical assistance to primary care providers to implement standardized

developmental screening and a process for referrals by identifying opportunities for quality improvement projects for

maintenance of certification within pediatric primary care practices.

A plan under development to add an electronic screening platform that integrates into EMRs and shares results with

primary care providers and other entities as designated by the child's family will be implemented and tested.

Increased coordination across MCH priorities through the integration of pregnancy related depression into existing

ABCD efforts will be supported by identifying communities to pilot the inclusion of maternal depression screening

with early childhood screening and referral in local referral roadmaps.

And, an analysis of data collected to demonstrate the impact and outcomes of screening and early intervention for

children will be used in the development of a policy agenda for screening, referral and follow-up.

State Performance Measure 5: Percent of Early Intervention Colorado referrals coming from targeted screening sources.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2008	2009	2010	2011	2012
Data					
Annual				42	43
Performance					
Objective					
Annual Indicator		34.3	41.7	42.5	41.9
Numerator		2885	3796	4059	4020
Denominator		8420	9101	9557	9586
Data Source		Early	Early	Early	Early
		Intervention	Intervention	Intervention	Intervention
		Colorado	Colorado	Colorado	Colorado
Is the Data				Final	Final
Provisional or					
Final?					
	2013	2014	2015	2016	2017
Annual	44	45	46	47	48
Performance					

Notes - 2012

Data for reporting year 2012 represent calendar year 2012. Data are provided by Early Intervention Colorado.

Notes - 2011

Data for reporting year 2011 represent calendar year 2011. Data are provided by Early Intervention Colorado.

Notes - 2010

Data for reporting year 2010 represent calendar year 2010. Data are provided by Early Intervention Colorado.

a. Last Year's Accomplishments

The annual indicator for reporting year 2012 showed that 41.9 percent of Early Intervention Colorado (EIC) referrals

came from targeted screening sources. The target for reporting year 2012 was 43.0 percent and it was not met.

Last year, the Assuring Better Child Health and Development (ABCD) project developed a Model Community

Framework based on lessons learned over the course of the last eight years. The Model Community Framework was

designed as a guide to help local community partners develop and implement a coordinated system of care to

improve developmental screening and referral of young children. Use of the Framework forms a platform for the

technical assistance and training ABCD provides to local public health agencies to engage partners in working

toward a coordinated system to improve developmental screening and referral rates.

ABCD continued to support alignment of the Early Childhood Health Integration Initiative funded by the Colorado

Trust and the MCH priority to increase developmental and social-emotional screening and referral rates for children

birth to age five in local communities. Early childhood councils in eight communities received funding through the

Health Integration Initiative in 2012.

In a continuing effort to improve data systems, EIC revised processes for tracking referral data by assigning a

unique identifier to each health care practice providing referrals for evaluation. This unique identifier is now used to

match referral data with screening data in the ABCD data base, providing more accurate tracking from screening to

referral by practice. ABCD's ability to integrate data from the two systems facilitates improved monitoring processes

that help identify needs and opportunities for training and technical assistance to health care practices.

Medicaid added a diagnosis code of "pass/fail" within the screening and billing process. This coding enhancement is

expected to help track children enrolled in Medicaid and ensure that referrals for evaluation are made.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service				
	DHC	ES	PBS	IB	
Supported HI communities in implementation of ABCD				Х	
practices					
2. Developed Model Community Framework				Х	
3. Began monitoring screening and referrals across two data				Х	
systems using a unique identifier for health care practices					
4. Used monitoring information to provide targeted technical				Х	
assistance and training to health care practices					
5.					
6.					
7.					
8.					
9.					
10.					

b. Current Activities

The target for reporting year 2013 is 44.0 percent.

ABCD is providing technical assistance to five early childhood councils that received Phase 2 funding from The

Colorado Trust to continue implementing a local Health Integration Initiative. All are working with local public health

agencies (LPHAs) to support collective efforts to improve coordination of local systems for developmental screening

and referral. Training materials and facilitation guides for the first two activities in the Model Community Framework

were completed and are being used to support communities in building strong partnerships and a referral road map.

LPHA staff is being trained to use the Model Communities Framework materials to co-facilitate trainings for

community partners with ABCD. This allows CDPHE to leverage local community efforts begun by early childhood

councils and to support LPHAs in engaging early childhood councils to support work without Health Integration

Initiative funding.

ABCD physician outreach coordinators are using Early Intervention Colorado referral data to provide feedback and

technical assistance to primary care providers to increase referrals from these targeted referral sources.

At the state level, creating a developmental screening registry was identified as one of thirteen priorities for the

Public Health and Health Information Exchange Steering Committee. This project will help avoid duplication of

screening and ensure health care providers have access to results.

c. Plan for the Coming Year

The target for reporting year 2014 is 45.0 percent.

The state will continue to explore the potential for a developmental screening registry through the Public Health and

Health Information Exchange Steering Committee. CDPHE and ABCD will be active participants in the Early

Childhood Colorado Partnership's initiative around mitigating toxic stress and trauma for infants and toddlers, and

support efforts to increase awareness and understanding of the importance of surveillance, screening and referral

of young children and families to identify and address physical, social, emotional and environmental factors that

contribute to poor developmental trajectories for children and stress within families. ABCD will continue to provide

technical assistance and support to communities currently implementing referral road maps and for new communities

interested in adopting the Model Community Framework to create a coordinated system of care for developmental

screening and referral.

State Performance Measure 6: Percent of live births where mothers gained an appropriate amount of weight during pregnancy according to pre-pregnancy BMI.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective	2008	2009	2010	2011	2012
and Performance					
Data					
Annual Performance				34	34
Objective					
Annual Indicator	32.0	32.3	33.0	33.1	33.2
Numerator	19242	19574	19974	21309	20964
Denominator	60040	60688	60500	64380	63147
Data Source	Birth	Birth	Birth	Birth	Birth
	certificates	certificates	certificates	certificates	certificates
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	34	34.5	35	35.5	36

Notes - 2012

Data for reporting year 2012 represent 2011 births. The data represent singleton births, 23+ weeks gestation. Appropriate weight gain according to prepregnancy body mass index for each week of gestational age was calculated based on the 2009 IOM Guidelines for Pregnancy Weight Gain.

Data for reporting years 2011 and 2012 are not comparable to data in earlier reporting years.

Notes - 2011

Data for reporting year 2011 represent 2010 births. The data represent singleton births, 23+ weeks gestation. Appropriate weight gain according to prepregnancy body mass index for each week of gestational age was calculated based on the 2009 IOM Guidelines for Pregnancy Weight Gain.

Data for reporting year 2011 are not comparable to data in earlier reporting years.

Data for reporting year 2010 represent 2009 births. Appropriate weight gain according to prepregnancy BMI was calculated based on the 1990 IOM Guidelines for Pregnancy Weight Gain.

a. Last Year's Accomplishments

The indicator for reporting year 2012 showed that 33.2 percent of live births were to mothers who gained an

appropriate amount of weight during pregnancy according to pre-pregnancy BMI. The target for reporting year 2012

was 34.0 percent which was not quite met.

The activities of the Early Childhood Obesity Prevention (ECOP) MCH Implementation Team described in NPM 14

identify pregnant women as a target population and appropriate gestational weight gain as a desired outcome.

Specifically, activities related to focus group testing of prenatal weight gain messages and the professional

development needs assessment of health professionals include a focus on gestational weight gain. Maternal

Wellness staff contributed to the health care systems and public health collaborative, which advised these

strategies. Local public health agencies that selected ECOP strategies related to food access, consistent messaging,

and improving health in worksites include pregnant women as a target population.

Colorado WIC's three-year ECOP plan also includes pregnant women as a target group (see NPM 14). In addition,

Colorado WIC offered the Maternal Nutrition Intensive Course to CDPHE staff, local WIC staff, and other public

health registered dietitians and nurses. This course is a training program regarding the latest prenatal nutrition

science and research.

The Maternal Wellness Team continued promotion of the Healthy Baby Campaign, focusing on appropriate prenatal

weight gain and preconception healthy weight using the life course perspective. The team offered consumer and

provider outreach via state and local agency activities.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyram	Pyramid Level of Service			
	DHC	ES	PBS	IB	
Developed ECOP state and local logic models and selected				Х	
local public health agency					
2. Completed message testing			X		
3. Conducted an ECOP professional development needs				Х	
assessment					
4. Completed WIC ECOP activities	Х	Х	Х	Х	
5. Offered the Maternal Nutrition Intensive Course				Х	
6. Promoted the Healthy Baby Campaign			X	Х	
7.					

8.		
9.		
10.		

b. Current Activities

The target for reporting year 2013 is 34.0 percent.

The current activities for NPM 14 are part of an integrated plan to prevent obesity during critical periods in the life

course, including the preconception, prenatal, and early childhood periods. In collaboration with the ECOP team, the

Maternal Wellness Team assisted in the revision and dissemination of prenatal weight gain messages and included

prenatal weight gain components in the online early childhood obesity prevention tools and resources for health

professionals. The Colorado WIC Wellness Coordinator System and local WIC agency nutrition education plans

intend to achieve appropriate gestational weight gain among women, well as the ECOP activities currently

underway by local public health agencies (NPM 14).

Additionally, the Maternal Wellness Team offered the Maternal Nutrition Intensive Course to CDPHE staff and local

WIC staff, and other public health dietitians and nurses.

c. Plan for the Coming Year

The target for reporting year 2014 is 34.5 percent.

The plans for the coming year for NPM 14 reflect reporting year 2014 activities for SPM 6. Specifically, activities

related to supporting local public health agency ECOP strategies, the ECOP impact evaluation, and WIC activities

include components focused on appropriate gestational weight gain. As in previous years, Colorado WIC will offer

the Maternal Nutrition Course for public health dietitians and nurses. The Maternal Wellness Team will also continue

to provide Healthy Baby Campaign materials to public health and health care partners.

State Performance Measure 7: Percent of parents reporting that their child (age 1 through 3) first went to the dentist by 12 months of age.

Tracking Performance Measures

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				3.4	10
Annual Indicator	2	2.8	3.4	11.2	10.3
Numerator					
Denominator					

Data Source	Colorado Child Health Survey				
Is the Data				Final	Final
Provisional or					
Final?					
	2013	2014	2015	2016	2017
Annual	11	12	13	14	15
Performance					
Objective					

Data for reporting year 2012 represent 2012 Colorado Child Health Survey results. This data point represents children ages 1-3, which can be compared to the RY2011 data point.

Estimates from RY2010 and earlier are not comparable to estimates from more current reporting years due to methodological changes.

Notes - 2011

Data for reporting year 2011 represent 2011 Colorado Child Health Survey results.

The 2011 Child Health Survey results reflect changes to sampling and weighting methodology based on the 2011 BRFSS changes, therefore annual indicators prior to reporting year 2011 should not be compared to the reporting year 2011 annual indicator.

4-4-13: Updated RY2011 data point to 11.2% due to shift in methodology (ask parents of 1-3 year olds, instead of parents of 1-5 year olds).

Notes - 2010

Data for reporting year 2010 represent 2010 Colorado Child Health Survey results.

a. Last Year's Accomplishments

The indicator for reporting year 2012 showed that 10.3 percent of parents reported their child (age one through

three) first went to the dentist by 12 months of age. The target for reporting year 2012 was 10.0 percent.

However, this target is not comparable to the current data due to Child Health Survey methodology changes and

the narrowing of the age range.

The Community Standards for Oral Health in the Toolkit for Promoting Maternal and Child Oral Health in Colorado

Communities state goals for all Colorado communities to achieve. These Standards were produced by the MCH

Implementation Team and vetted by local and state level stakeholders. The Standards were used as part of the

framework for the State Oral Health State Plan, released in September 2012.

The CDPHE Oral Health Unit applied for and was awarded a HRSA Oral Health Workforce grant to support

implementation of the guidelines and toolkit on a community-level.

Both prenatal and oral health providers are limited in providing oral health care during pregnancy. This is often

caused by a general lack of understanding about the impact and safety of care provided to pregnant women. Many

dentists needlessly withhold or delay treatment of pregnant patients because of fear about injuring the woman or

the fetus or because of fear of litigation. Plans to adopt a statewide Guidelines for Oral Health Care During

Pregnancy and Early Childhood were initially delayed due to feedback from stakeholders about the need for more

state-specific data. Addition of new data from CDPHE's 2011-12 School Oral Health Screening Survey (BSS) and Child

Health Survey to the guidelines to ensure the most up-to-date local data is planned.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
Adopted Guidelines for Oral Health Care during Pregnancy and Early Childhood				Х
2. Established Colorado Community Health Standards for a				Х
healthy dental community				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2013 is 11.0 percent.

The MCH Implementation Team discontinued work when the MCH oral health coordinator position became vacant.

The Oral Health Winnable Battle Collaborative now provides input for the MCH oral health state action plan. CDPHE

staff was updating California's guidelines on treating pregnant women. The Collaborative was planning to revise

and brand them as Colorado's recommended guidelines. However, the National Maternal and Child Oral Health

Resource Center requested that Colorado utilize the MCH Oral Health Care During Pregnancy Guidelines: A National

Consensus Statement instead of branding state-specific guidelines. CDPHE collaborated with the resource center

and the Colorado Dental Association to co-release the guidelines, along with a fact sheet with state-specific data on

pregnant women and oral health. Over 3,500 dental and medical providers received the guidelines.

Five contracts with local public health agencies (LPHAs), supported by the HRSA oral health workforce grant.

required utilization of A Toolkit for the Promotion of Oral Health in Colorado Communities. Baseline phone interviews

conducted in late 2012 showed that none of the LPHA staff was currently utilizing the toolkit. The Toolkit, with

updated references, was posted on the state oral health coalition's website at:

http://www.oralhealthcolorado.org/wp-content/uploads/2011/06/PromotingOralHealthToolkitF.pdf.

c. Plan for the Coming Year

The target for reporting year 2014 is 12.0 percent.

Activities previously described will continue. In addition, CDPHE will administer the Cavity Free at Three (CF3)

program beginning in the fall of 2013. A main goal of CF3 is to increase age one dental visits. CF3 teaches medical

and dental staff to perform oral health risk assessments, motivational interviewing, fluoride varnish application, and

oral examinations of infants. CF3 helps private dental practices enroll as Medicaid and Children's Health Plan Plus

(CHIP) providers. CF3 staff will disseminate the pregnancy treatment guidelines during trainings and present the

pregnancy treatment guidelines to all Federally Qualified Health Center (FQHCs) dental directors by early 2014.

CDPHE will disseminate the caries risk assessment developed by CF3 to CDPHE HRSA grantees and other partners

to align the use of state assessment tools.

In 2014, CDPHE will draft a fact sheet about the national initiative, Preventing Abuse and Neglect through Dental

Awareness (PANDA). A PANDA fact sheet will be distributed with new mailings of the abovementioned pregnancy

treatment guidelines and will provide guidance on identifying and reporting domestic abuse in the dental setting,

including Colorado-specific procedures and laws. CDPHE will either develop an accompanying webinar with

continuing education credits for dental providers or receive permission to distribute an alreadyexisting webinar from

another state or federal agency.

CDPHE will also work with the state licensing agency on the Dental Practice Act Sunset for 2014 to propose

mandatory continuing education credits, including a PANDA credit requirement.

Educating providers about the legal requirements to report suspected abuse as well as the clinical signs of abuse

will be especially important in the coming year. This is because a new Medicaid adult dental benefit will be

implemented in July 2014. The new coverage will expand access to high-risk pregnant women. CF3, CDPHE, the

Colorado Dental Association and other partners will actively work to increase utilization of the dental benefit by all

adults, especially pregnant women. This will improve the health of women during and after pregnancy and increase

the likelihood of an age one dental visit children. Incorporating PANDA into the pregnancy treatment guidelines and

CF3's work can help protect both mother and child from domestic abuse.

State Performance Measure 8: Percent of sexually active high school students using an effective method of birth control to prevent pregnancy.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				27	30
Annual Indicator		19.3	26.4	29.1	29.1
Numerator					
Denominator					
Data Source		Youth Risk Behavior Survey	Youth Risk Behavior Survey	Youth Risk Behavior Survey	Youth Risk Behavior Survey
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	30	30.5	31	31.5	32

Notes - 2012

Data for reporting year 2012 represent 2011. The 2011 YRBS was weighted. Effective birth control includes birth control pills and Depo-Provera. Data are available at www.chd.dphe.state.co.us/Resources/yrbs/2011/2011COH%20Summary%20Tables.pdf

Notes - 2011

Data for reporting year 2011 represent 2011. The 2011 YRBS was weighted. Effective birth control includes birth control pills and Depo-Provera.

Notes - 2010

Data for reporting year 2010 represent 2009. The 2009 YRBS was weighted. Effective birth control includes birth control pills and Depo-Provera. Data are available at http://apps.nccd.cdc.gov/youthonline/App/Default.aspx?SID=HS

a. Last Year's Accomplishments

The indicator for reporting year 2012 showed that 29.1 percent of sexually active high school students used an

effective method of birth control to prevent pregnancy. The target for reporting year 2012 was 30.0 percent and it

is unknown whether the target was met because updated data were not available for reporting year 2012.

CDPHE released Youth Sexual Health: A Call to Action, a tool and resource for communities to take action to

improve youth sexual health. This document, created in partnership with youth and communities across Colorado,

includes research, guidance and a number of evidence-based strategies that communities can incorporate into

their own community action plan. Feedback was gathered through youth interviews, focus groups, community

conversations, a statewide survey and a public comment period. The Call to Action is structured using the socio-

ecological model (spheres of influence) and gives strategy recommendations for each level or sphere - individual,

family network, community and policy/system. The social determinants of health and positive youth development

frameworks are also integrated throughout.

MCH staff continued to partner with The Colorado Initiative to Reduce Unintended Pregnancies and Vermilion Inc.

on the public awareness campaign, Beforeplay, which launched in February 2012. Campaign materials are placed

in various media across the state (see SPM 1 for more information). The website (www.beforeplay.org) provides a

clinic locator and interactive reproductive health information for youth, parents, men, women and health care

professionals.

In January 2012, Colorado announced "unintended pregnancy" as one of its 10 Winnable Battles. Prevention of

teen pregnancy is included in this Winnable Battle. The unintended pregnancy Winnable Battle has a Google

Group listserv for sharing information and quarterly meetings with other agency partners. Local public health

agencies have also identified preventing unintended pregnancy as a priority.

LARC use among young women served by the Title X Family Planning Program ages 15-19 more than doubled

from 2,444 users in 2009 to 5,040 users in 2012. During the same time period, Colorado experienced a 34

percent decline in the teen fertility rate and a 45 percent decline in the number of repeat (2nd order or higher)

births to teens.

Other MCH action plan items included researching parent/child communication curriculums, which CDPHE will be

implementing regionally over the next year, and convening the Youth Sexual Health Team, which is an inter-

agency workgroup to increase alignment of statewide work.

CDPHE staff contributed to Colorado Youth Matter's annual report, the State of Adolescent Sexual Health in

Colorado, which uses CDPHE data to provide a brief summary of relevant state and national data, along with

providing a picture of how Colorado has progressed over time.

MCH staff served on the planning committee of the first Sexual Health Across the Lifespan conference, working to

ensure that youth sexual health was a prominent aspect of the conference.

MCH staff worked with two MPH graduate students to conduct two assessments to support the MCH state action

plan. The first was a scan of parent-child communication interventions that helped determine the most

appropriate trainings to hold across the state. The second was a scan of youth sexual health policies in place at

the state-level and within Denver and Jefferson Counties. This scan includes the specific policy language, coupled

with a "Simply Stated" section so it is easy to understand.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			/ice
	DHC	ES	PBS	IB
Released statewide youth sexual health plan				X
2. Planned sexual health across the lifespan conference				X
3. Compiled information on parent/child communication curriculums				Х
4. Supported the release of reports relevant to youth sexual				X
health				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2013 is 30.0 percent.

CDPHE's Youth Sexual Health: A Call to Action was released in Denver and Pueblo at events that included both

youth and adult participants. CDPHE presented the Call to Action and discussed state sexual health plans with other

state and national partners at a National Coalition of STD Directors' meeting. Staff continues to provide technical

assistance on implementing strategies from the Call to Action. Additionally, staff continues to convene the Youth

Sexual Health Team comprised of three other state agencies -- Colorado Departments of Education, Human Services

and Health Care Policy and Financing.

MCH staff successfully advocated for the inclusion of sexual health education questions in the department's

statewide "Child Health Survey." These will serve as a baseline toward increased parent-child communication on

sexual health topics. Additionally, MCH staff contracted with a statewide technical assistance provider, Colorado

Youth Matter, to conduct parent-child communication/ connectedness trainings.

MCH staff hired two Youth Advisor positions at CDPHE, one of which is focusing on improving youth sexual health.

One of her projects includes working in partnership with Family Planning staff to improve the "youth-friendliness" of

Title X clinics.

c. Plan for the Coming Year

The target for reporting year 2014 is 30.5 percent.

Activities will continue from the previous year.

Staff will build off of the success of Denver Health's Westwood Speaks project, which was funded

by the

Preventative and MCH Block Grants. This project modified a parent-child connectedness curriculum and paired it with

a communication curriculum. Since it has shown successful results, CDPHE and its partners plan to replicate it across

the state through a contract with Colorado Youth Matter.

MCH staff will continue partnering with Family Planning staff at CDPHE on a project to help improve the "youth

friendliness" of Title X clinics. The information learned from the pilot site will be shared with other clinics and joint-

learning opportunities will be convened.

CDPHE will continue to convene the Youth Sexual Health Team. The team is choosing to focus its efforts on

parent/family engagement, education and connectedness regarding youth sexual health in order to build an

infrastructure for "askable adults" across the state. This focus not only supports several strategies listed in the Call

to Action's statewide logic model, but it also aligns with the MCH action plan.

CDPHE will continue its work around the Winnable Battle of unintended pregnancy. In order to fully address this

topic, the department is focusing on sexual health across the lifespan and is aiming to change social norms around the topic.

Local public health agencies will continue to use the Call to Action in planning efforts and participate on the Youth

Sexual Health Team. They will also partner with MCH staff to outreach and support local parentchild communication

trainings. Boulder will continue to refocus a local youth sexual health coalition to focus on the county's population

based approaches, while Denver continues to work to publish the results of the parent-child connectedness

curriculum they implemented in Denver's Westwood neighborhood.

State Performance Measure 9: Motor vehicle death rate for teens ages 15-19 years old.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective	2008	2009	2010	2011	2012
and Performance Data					
Annual Performance Objective				12.5	12
Annual Indicator	17.0	14.0	12.7	12.1	10.3
Numerator	61	51	46	41	36
Denominator	358249	363012	362423	339475	349522
Data Source	Death certificates				
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017

Annual Performance	10.1	10	9.9	9.8	9.7
Objective					

Data for reporting year 2012 represent calendar year 2011 deaths.

Notes - 2011

Data for reporting year 2011 represent calendar year 2010 deaths.

Notes - 2010

Data for reporting year 2010 represent calendar year 2009 deaths.

a. Last Year's Accomplishments

The indicator for reporting year 2012 was 10.3 deaths per 100,000 teens ages 15-19 years old caused by motor

vehicles. The target for reporting year 2012 was 12.0 deaths per 100,000 teens and the target was met. A total

of 36 deaths among teens 15 to 19 years old were due to motor vehicle crashes.

Colorado was one of ten states to receive a Motor Vehicle Policy grant from the Centers for Disease Control and

Prevention. The ISVP Branch received \$750,000 over five years to 1) strengthen Colorado's graduated driver's

license law by increasing the minimum driving age and expanding the restricted driving hours for teens; and 2)

establish a statutory requirement that allows for primary enforcement of Colorado's seat belt law. This project will

continue through July 2016.

The ISVP Branch continued to convene the Colorado Teen Driving Alliance (CTDA). The CTDA implemented

strategies outlined in the Motor Vehicle Policy Plan to educate the public about the importance of the GDL law.

The CTDA developed a three-year state logic model and action plan to reduce teen motor vehicle fatalities, and

implemented the year two activities outlined in the both plans. The CTDA, local public health agencies, and other

key local partners developed a complementary local logic model and action plan template. These logic models and

action plans are aligned with the goals and objectives in the ISVP Branch's CDC Motor Vehicle Policy grant. The

ISVP Branch surveyed law enforcement personnel from around the state on their knowledge and enforcement of

the Graduated Driver Licensing laws to identify areas for training, technical assistance, and education.

The Injury and Violence Policy Committee (IVPC) provided support to the CTDA to address policy activities outlined

in the policy plan. The ISVP Branch and the EPE Branch also developed evaluation plans for state and local action plans.

The CTDA created a Safety Advocate Section of the www.coteendriver.com website to house resources for local

programs working on SPM 9. Additionally, the ISVP Branch developed a collaborative website for motor vehicle

partners (www.teendrivingallianceco.com).

In 2012, CDPHE named motor vehicle safety as one of Colorado's Winnable Battles, public health priorities where

progress can be made in the next five years. Although motor vehicle crashes have declined significantly over the

past 15 years, it remains one of the leading causes of injuries and deaths in Colorado. To continue to see

decreases in motor vehicle-related health outcomes, state and local partners must work together to implement

evidence-based policy strategies known to decrease motor vehicle injuries and deaths. In order to garner local-

level support for Colorado's motor vehicle Winnable Battle and increase knowledge about prevention strategies,

CDPHE partnered with members of the Colorado Teen Driving Alliance (CTDA) to host a Motor Vehicle Winnable

Battle Academy in July 2012.

Ninety-six participants represented a variety of disciplines including: public health, hospital systems, law

enforcement, schools, local traffic safety coalitions, insurance companies, and small businesses. Additionally,

several teams included parents and teens as members. Participants increased their understanding about why

motor vehicle safety was named as one of Colorado's 10 Winnable Battles and had the opportunity to learn

about program and policy activities occurring around the state. Local teams worked with their mentors to refine

the community-specific motor vehicle problem they identified in their applications using available data. Teams also

conducted stakeholder analyses to identify where they needed to develop partnerships. Teams ultimately created

local action plans to take back to their communities.

The Alliance monitored motor vehicle-related legislation during the 2012 legislative session.

The Colorado Child Fatality Prevention State Review Team's 2012 Legislative report included recommendations to

establish a statutory requirement that allows for primary enforcement of the seat belt law and to increase

parental awareness and support enforcement of the GDL Law.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service				
	DHC	ES	PBS	IB	
Coordinated and maintained the Colorado Teen Driving Alliance				X	
Maintained the Safety Advocate Section of the COTeenDriver.com				Х	
3. Coordinated and maintained the Injury and Violence Policy Committee				X	
4. Hosted a Motor Vehicle Policy Symposium to support the Motor Vehicle Winnable Battle				Х	
5. Implemented the state Motor Vehicle Action Plan				Χ	

6. Provided technical assistance to local public health agencies		Х
related to this priority		
7. Implemented the activities outlined in the Colorado Motor		Χ
Vehicle Policy Grant		
8. Made legislative recommendations from the Colorado Child		Χ
Fatality Prevention State Review Team to reduce child death		
9.		
10.		

b. Current Activities

The target for reporting year 2013 is 10.1 deaths per 100,000 teens.

The ISVP Branch convened the CTDA. The CTDA is implementing activities outlined in the three-year state action,

policy, and evaluation plans to reduce teen motor vehicle fatalities.

The CTDA is providing technical assistance to agencies implementing local motor vehicle safety activities. The ISVP

Branch implemented a statewide parent survey on knowledge and at-home enforcement of GDL laws. The results

were used to develop an online training for parents to increase knowledge and enforcement of the law.

The Colorado Department of Transportation (CDOT) is funding a permanent motor vehicle statistical analyst position within the ISVP Branch.

ISVP initiated an Injury Prevention Winnable Battle Champion program to recognize professionals implementing

evidence-based motor vehicle safety practices.

The ISVP Branch is maintaining the motor vehicle collaboration website and the Safety Advocate Section on coteendriver.com.

The CTDA monitored motor vehicle-related legislation during the 2013 session and educated partners on best

practices to strengthen the GDL laws while providing supporting data and resources. ISVP also educated

stakeholders on the National Highway Traffic Safety Administration's guidance on strengthening GDL laws.

The Colorado Child Fatality Prevention State Review Team's 2013 Legislative report recommended strengthening

Colorado's GDL laws and passing primary seat belt legislation.

c. Plan for the Coming Year

The target for reporting year 2014 is 10.0 deaths per 100,000 teens.

The ISVP Branch will continue to convene the Colorado Teen Driving Alliance (CTDA) and the Injury and Violence

Policy Committee. The CTDA will implement activities outlined in the three-year state action and evaluation plans

to reduce teen motor vehicle fatalities.

ISVP Branch staff will expand the Injury Prevention Winnable Battle Champion program to continue to train and

recognize local injury prevention advocates who are implementing evidence-based practices to reduce child

fatalities. ISVP staff will provide at least 12 training opportunities to increase the capacity of these champions to

implement policy and programmatic best practices.

The ISVP Branch will use results from the parent GDL survey conducted in 2013 to market parent training

opportunities on GDL laws and best practices to reduce teen fatalities.

The CTDA will provide technical assistance to local health departments and other community-based agencies that

are implementing local motor vehicle safety activities. The CTDA will provide training and technical assistance

opportunities as needed.

The ISVP Branch will maintain the motor vehicle collaboration website (teendrivingallianceco.com). The Colorado

Department of Transportation will maintain the www.coteendriver.com website and ensure that the Safety

Advocate Section is up-to-date.

The Alliance will monitor motor vehicle-related legislation during the 2014 legislative session. The ISVP Branch will

educate stakeholders on Colorado's current GDL laws and the changes required to align those laws with the

National Highway Traffic Safety Administration's recommendations.

The ISVP Branch and its partners will continue to implement activities under Colorado Child Motor Vehicle Policy

Grant, including the compilation of county- and statewide data on motor vehicle crashes, fatalities,

hospitalizations, and recommendations for improvement. This data will be compiled into the Colorado Department

of Transportation's 2014 Problem Identification Report and will be used by counties and regions to apply for

motor vehicle safety funding. Additionally, the ISVP Branch will work with statewide injury prevention funders to

strengthen granting opportunities that increase the number of evidence-based programs funded across the

state.

The Colorado Child Fatality Prevention State Review Team's 2014 Legislative report will include recommendations

to strengthen motor vehicle safety legislation that will reduce teen driving fatalities.

State Performance Measure 10: The percent of group members that invest the right amount of time in the collaborative effort to build a youth system of services and supports.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

	[3e65 465 (2)(2)(b)(iii) and 460 (a)(2)(A)(iii)]										
I	Annual Objective	2008	2009	2010	2011	2012					

and Performance Data					
Annual				30	90
Performance					
Objective					
Annual Indicator			20.0	90.0	75.0
Numerator			2	9	6
Denominator			10	10	8
Data Source			Wilder	Wilder	Wilder
			Collaboration	Collaboration	Collaboration
			Factors Inventory	Factors Inventory	Factors Inventory
Is the Data			-	Final	Final
Provisional or					
Final?					
	2013	2014	2015	2016	2017
Annual	80	80	85	85	90
Performance					
Objective					

Data for reporting year 2012 were collected in October 2012.

Notes - 2011

Data for reporting year 2011 were collected in November 2011.

Notes - 2010

Data for reporting year 2010 were collected in October 2010 as the baseline for this state performance measure.

a. Last Year's Accomplishments

The annual indicator for reporting year 2012 was 75.0 percent. The target for reporting year 2012 was 90.0

percent and the target was not met.

As the MCH Implementation Team for this MCH priority, the PSD Healthy Youth Team created a state logic model

and action plan, incorporating both the internal and external youth systems-building work, which have been

developed and shared with local public health agencies and partners. The Youth Friendly Policy, now titled Youth

Friendly Guidance, was formally adopted by both the Prevention Services Division (PSD) and CDPHE. An

accompanying document entitled, Paths to Engaging Youth at CDPHE was developed to support the

implementation of the guidance. Two learning communities were hosted by PSD Healthy Youth Team members

regarding integration of youth programs and positive youth development. Two MCH personnel participated in

AMCHP's Youth Systems Roundtable in Washington D.C. They shared the Colorado9to25 (CO9to25) youth

systems-building work with other state and national partners. According to AMCHP and State Adolescent Health

Resource Center staff members who provide technical assistance to all states, CO9to25 is viewed as an

innovative and successful approach to systems-building, as it encompasses a positive youth

development

approach, seeks to impact all levels of the socio-ecological model and has actively been created in partnership

with young people.

MCH staff and partners reviewed and updated the CO9to25 Leadership Team Charter, resulting in better

understanding of participants' roles and responsibilities. Partners included, but are not limited to, young people

and adult representatives from various programs within CDPHE, CDE, CDHS, Department of Local Affairs, Kaiser

Permanente, youth serving non-profits, University of Colorado, local public health agencies and local school

districts. Leadership team members also conducted outreach to several key influential partners to engage them in

CO9to25 work. Key infrastructure documents were developed including a CO9to25 Strategic Map. CO9to25

Summary and Draft CO9to25 Framework and logo. These were all developed in partnership with youth and

shared with partners to guide this systems-building work. In addition, a logic model specific to CO9to25 was

developed. The completion of these documents helped narrow the focus in reaching tangible outcomes that will

ultimately lead to larger systems change. These documents have also helped clarify what the role of CO9to25 is

in relation to what communities need, while supporting their current work. The "frame" that has resonated the

most is that CO9to25 serves as a platform to support youth programs and efforts to achieve their goals in a

coordinated way. A website and other social media accounts were established which gave CO9to25 an online

presence and increased its visibility with youth as demonstrated by a steady increase in the "weekly reach"

information accessed from Facebook.

After developing this infrastructure, CO9to25 was officially launched at a stakeholder event in Denver. The launch

was a huge success as it put into practice a positive youth development approach which included a partnership

with young people. With a youth taking the lead in planning, organizing and facilitating the launch, its reach to

young people was apparent, as there were 61 diverse youth, between the ages of 9-25 present at the launch (in

addition to the 75+ adults). Attendees were diverse. They were from various socio-economic statuses,

geographic locations, and life experiences such as living situations including young people in group homes and

one woman transitioning into homelessness. Both youth and adults in attendance reported that the event was

engaging and inspiring, encouraging them to get involved in CO9to25. In addition, MCH staff traveled to Pueblo

where they held the first regional launch to ensure rural and urban areas across the state can incorporate the

CO9to25 Framework into their work as well.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Se			
	DHC	ES	PBS	IB
Increased coordination of youth serving programs				Х
2. Integrated CO9to25 and positive youth development into programs				Х
3. Mobilized internal and external partnerships to support the work				Х
4. Created a sustainable infrastructure for CO9to25				Х
5. Hosted regional launches to raise awareness of CO9to25				Х
6. Conducted trainings and learning communities on CO9to25 framework				Х
7. Participated in AMCHP Youth Systems Roundtable				Х
8. Developed, promoted and implemented policies supporting youth system-building				Х
9.				
10.				

b. Current Activities

The target for reporting year 2013 is 80.0 percent.

The PSD Healthy Youth Team has created and is implementing a new action plan. The work consists of training

youth-serving staff to integrate positive youth development and the CO9to25 Framework into their programs as well

as promote it with external partners. In addition, the "Youth Friendly Guidance" is being utilized by a number of

units/branches. For example, three youth advisors were hired, two of which are permanent employees.

CO9to25 continues to address coordination of state and local youth systems efforts by mobilizing partnerships with

internal and external stakeholders and co-leading CO9to25 leadership team meetings. The website and social media

accounts are active, resulting in increased awareness of the effort. The CO9to25 Framework, logo and branding has

been developed and shared with partners. An action plan, including an evaluation plan, has been developed and is

being implemented. A portion of this action plan includes hosting a statewide youth summit that included hundreds

of young people across the state gathering to coordinate and enhance the capacity of the statewide network of

youth advisory councils/groups. This increased leadership capacity of the participants can lead to an increase in

youth-adults partnership and engagement. MCH staff members continue to provide numerous trainings that build

the capacity of hundreds of state, local and national (AMCHP) partners to effectively engage youth.

c. Plan for the Coming Year

The target for reporting year 2014 is 80.0 percent.

The PSD Healthy Youth Team will continue fulfilling the state action plan by increasing the capacity of youth-serving

staff to integrate positive youth development and CO9to25 Framework into the department as well as promote it

with other internal and external partners. This will be done through the development of a "speaker's bureau" and a

series of trainings and learning communities with staff. In addition, this team will continue working to improve the

communication between youth-serving staff within the division.

MCH staff will continue to support CO9to25 by implementing portions of the action plan, including increasing

coordination and integration of positive youth development among internal youth-serving programs; supporting the

infrastructure of the CO9to25 Leadership Team and network by using a collective impact model; and promoting the

CO9to25 Framework with state and local partners through webinars and in-person trainings. Staff will maintain an

active CO9to25 website, using the new logo and branding which provides clarity and consistency in how CO9to25 is

communicated. This will help in improving the effectiveness in engaging community stakeholders who can implement

the related CO9to25 materials and tools (e.g. youth engagement standards, website). In addition, the CO9to25

Leadership Team will finalize the standards for effective and meaningful youth engagement, sharing them with

state, local and national partners. This policy change supports the MCH activity of "assessing and developing policies

that support a coordinated and integrated youth system."

MCH staff will also continue to conduct CO9to25 regional launches around the state to share effective systems-

building strategies with rural and frontier communities. Based on progress and need, a local logic model and action

plan will be developed.

E. Health Status Indicators

Health Status Indicators 01A: The percent of live births weighing less than 2,500 grams.

Health Status Indicators Forms for HSI 01A - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	9.0	8.9	8.8	8.8	8.7
Numerator	6397	6263	6015	5816	5659
Denominator	70804	70028	68605	66346	65052
Check this box if you cannot report the numerator					
because					
1. There are fewer than 5 events over the last year,					
and					
2. The average number of events over the last 3 years					
is fewer than 5 and therefore a 3-year moving					

average cannot be applied.			
Is the Data Provisional or Final?		Final	Final

Data for reporting year 2012 are calendar year 2011 births.

Notes - 2011

Data for reporting year 2011 are calendar year 2010 births.

Notes - 2010

Data for reporting year 2010 are calendar year 2009.

Narrative:

The low birth weight rate in Colorado began to decline in 2009, and reached 8.7 percent in 2012, its lowest level

since 2000 when it was 8.4 percent. The prevalence of smoking among pregnant women has been falling and may

explain some of the decline. According to a recent analysis of Colorado data, just one in every 14 low weight births

is attributable to smoking compared to one in eight in the late 1990s. However, one in eight low weight births

continues to be attributable to inadequate weight gain in pregnancy, a ratio which has not improved since that time.

These two factors, smoking and inadequate weight gain together account for one in every five low weight births in

the state.

Inductions and C-sections, also implicated in low birth weight and prematurity, have climbed since the late 1990s,

although the proportion of inductions remained constant at about one in five deliveries, while C-sections reached

the highest level ever (26.4 percent) in 2010. The first decline in C-sections since the mid-1990s occurred in 2011

(25.9 percent) and remained at the same level in 2012. The prematurity rate (births occurring before 37 weeks

gestation) has fallen, dropping to 9.1 percent in 2011 and 8.9 percent in 2012 after a high of 10.2 percent in 2006.

Multiple births, a significant contributor to low birth weight, have remained at 3.2 percent to 3.4 percent of all births

every year since 2003.

There was a sharp decline in the number of high-risk births statewide since 2008. These births are defined as those

occurring among unmarried women under the age of 25 who have less than a high school education. In 2008, 4,983

births took place to this group, but in 2012, the number fell 36 percent to 3,177. Since the low birth weight rate is

elevated among high-risk births, a decline in the number of high-risk births may well have contributed to the

reduction in the low birth weight rate.

Health Status Indicators 01B: The percent of live singleton births weighing less than 2,500 grams.

Health Status Indicators Forms for HSI 01B - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	7.1	7.1	6.8	6.9	7.0
Numerator	4874	4826	4534	4403	4382
Denominator	68426	67812	66260	64119	62995
Check this box if you cannot report the numerator					
because					
1. There are fewer than 5 events over the last year,					
and					
2. The average number of events over the last 3 years					
is fewer than 5 and therefore a 3-year moving					
average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2012

Data for reporting year 2012 are calendar year 2011 births.

Notes - 2011

Data for reporting year 2011 are calendar year 2010 births.

Notes - 2010

Data for reporting year 2010 are calendar year 2009.

Narrative:

The singleton low birth weight rate for 2012 was 7.0 percent, little change from the rates shown for other years.

Trends in low birth weight are discussed above.

Health Status Indicators 02A: The percent of live births weighing less than 1,500 grams.

Health Status Indicators Forms for HSI 02A - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	1.3	1.3	1.2	1.3	1.3
Numerator	930	928	839	889	830
Denominator	70804	70028	68605	66346	65052
Check this box if you cannot report the numerator					
because					
1. There are fewer than 5 events over the last year,					
and					
2. The average number of events over the last 3 years					
is fewer than 5 and therefore a 3-year moving					
average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2012

Data for reporting year 2012 are calendar year 2011 births.

Notes - 2011

Data for reporting year 2011 are calendar year 2010 births.

Notes - 2010

Data for reporting year 2010 are calendar year 2009.

Narrative:

Colorado's very low birth weight rate for 2012 was 1.3 percent, the same as the rate for 2011. The very low birth

weight rate was only slightly lower at 1.2 percent in two other years-- 2000 and 2010.

Health Status Indicators 02B: The percent of live singleton births weighing less than 1,500 grams.

Health Status Indicators Forms for HSI 02B - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	1.0	1.0	0.9	1.0	1.0
Numerator	688	678	624	629	608
Denominator	68426	67812	66260	64119	62995
Check this box if you cannot report the numerator					
because					
1. There are fewer than 5 events over the last year,					
and					
2. The average number of events over the last 3 years					
is fewer than 5 and therefore a 3-year moving					
average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2012

Data for reporting year 2012 are calendar year 2011 births.

Notes - 2011

Data for reporting year 2011 are calendar year 2010 births.

Notes - 2010

Data for reporting year 2010 are calendar year 2009.

Narrative:

The singleton very low birth weight rate for 2012 was 1.0 percent. Since 2000, this rate has fluctuated between 0.9 percent and 1.0 percent.

Health Status Indicators 03A: The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

Health Status Indicators Forms for HSI 03A - Multi-Year Data

Annual Objective and Performance	2008	2009	2010	2011	2012
Data					
Annual Indicator	5.4	6.5	6.6	6.3	5.4
Numerator	55	67	69	65	56
Denominator	1019648	1036835	1040402	1025217	1034643
Check this box if you cannot report the					
numerator because					
1.There are fewer than 5 events over					
the last year, and					
2.The average number of events over					
the last 3 years is fewer than 5 and					
therefore a 3-year moving average					
cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Data for reporting year 2012 are calendar year 2011. Data were obtained from the Colorado Health Information Dataset at http://www.cdphe.state.co.us/cohid/.

Notes - 2011

Data for reporting year 2011 are calendar year 2010 deaths.

Notes - 2010

Data for reporting year 2010 are calendar year 2009. Data were obtained from the Colorado Health Information Dataset at http://www.cdphe.state.co.us/cohid/.

Narrative:

Colorado child deaths due to unintentional injuries continued to decline in 2012 with a rate of 5.4 deaths per

100,000. Previous child death rate highs due to unintentional injuries were 6.3 per 100,000 in 2011 and 6.6 per

100,000 in 2010.

Health Status Indicators 03B: The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

Health Status Indicators Forms for HSI 03B - Multi-Year Data

Annual Objective and Performance	2008	2009	2010	2011	2012
Data					
Annual Indicator	2.7	2.6	2.3	2.0	2.1
Numerator	28	27	24	20	22
Denominator	1019648	1036835	1040402	1025217	1034643
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average					
cannot be applied. Is the Data Provisional or Final?				Final	Final

Notes - 2012

Data for reporting year 2012 are calendar year 2011 deaths.

Notes - 2011

Data for reporting year 2011 are calendar year 2010 deaths.

Notes - 2010

Data for reporting year 2010 are calendar year 2009. Data were obtained from the Colorado Health Information Dataset at http://www.cdphe.state.co.us/cohid/.

Narrative:

The child death rate due to motor vehicle crashes in 2012 was 2.1 per 100,000. This rate is slightly higher than the

previous 2011 rate of 2.0, but still lower than the last five years with the highest rate of 3.2 shown in 2006.

Health Status Indicators 03C: The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

Health Status Indicators Forms for HSI 03C - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	18.2	16.4	13.6	14.5	14.3
Numerator	134	123	102	100	99
Denominator	736038	748317	748829	688090	693800
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2012

Data for reporting year 2012 are calendar year 2011 deaths.

Notes - 2011

Data for reporting year 2011 are calendar year 2010 deaths. The annual indicator increased slightly because the denominator decreased after adjustments were made to the population estimates based on the 2010 census results. This age group was most affected by the population updates.

Notes - 2010

Data for reporting year 2010 are calendar year 2009. Data were obtained from the Colorado Health Information Dataset at http://www.cdphe.state.co.us/cohid/.

Narrative:

The death rate in 2012 among youth ages 15 to 24 due to motor vehicle crashes was 14.3 per 100,000, slightly

lower than the 2011 rate of 14.5. However, the number of deaths --99-- fell below 100 for the first time in decades.

Between 2008 and 2011, the number of deaths ranged between 100 and 134, and as recently as 1997, the number

was 172.

Changes in Graduated Driver Licensing laws (instituted in 1999) are being credited with much of the decline. In

2005, Colorado strengthened the laws to limit passengers riding with inexperienced drivers, to prohibit learners'

permit holders to use cell phones while driving, and to require seatbelts for all occupants under age 18. A new driver

under age 18 cannot have any passengers under age 21 until the driver has held a driver's license for at least six

months. In addition, a new driver under age 18 cannot have more than one passenger under age 32 until the driver

has had his license for at least one year.

Health Status Indicators 04A: The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.

Health Status Indicators Forms for HSI 04A - Multi-Year Data

Annual Objective and Performance	2008	2009	2010	2011	2012
Data					
Annual Indicator	162.2	172.4	163.9	160.4	172.7
Numerator	1654	1787	1705	1644	1774
Denominator	1019648	1036835	1040402	1025217	1027196
Check this box if you cannot report the					
numerator because					
1.There are fewer than 5 events over					
the last year, and					
2.The average number of events over					
the last 3 years is fewer than 5 and					
therefore a 3-year moving average					
cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2012

Data for reporting year 2012 are calendar year 2011 injuries from the Colorado Hospital Association inpatient data set. Data represent nonfatal injuries to Colorado residents ages 0 through 14. The denominator represents the 2011 population ages 0 through 14 obtained from the Colorado Health Information Dataset at http://www.chd.dphe.state.co.us/cohid/Default.aspx.

Notes - 2011

Data for reporting year 2011 are calendar year 2010 injuries from the Colorado Hospital Association inpatient data set. Data represent nonfatal injuries to Colorado residents ages 0 through 14. The denominator represents the 2010 population ages 0 through 14 obtained from the Colorado Health Information Dataset at http://www.chd.dphe.state.co.us/cohid/Default.aspx.

Notes - 2010

Data for reporting year 2010 are calendar year 2009 from the Colorado Hospital Association inpatient data set. Data represent nonfatal injuries to Colorado residents ages 0 through 14. The denominator represents the 2009 population ages 0 through 14 obtained from the Colorado Health Information Dataset at http://www.cdphe.state.co.us/cohid/.

Narrative:

In 2012, the rate of non-fatal injuries for children 14 and younger was 172.7 per 100,000. This is an increase from

the rate of 160.4 per 100,000 in 2011; 2011 had the lowest rate of the last decade. Despite the increase compared

to the previous year, the 2012 rate reflects an overall decrease since 2004 when the rate was 187.4 per 100,000.

Health Status Indicators 04B: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

Health Status Indicators Forms for HSI 04B - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	22.5	23.2	22.8	19.5	19.0
Numerator	229	241	237	200	195
Denominator	1019648	1036835	1040402	1025217	1027196

Check this box if you cannot report the			
· · · · · · · · · · · · · · · · · · ·			
numerator because			
1.There are fewer than 5 events over			
the last year, and			
2.The average number of events over			
the last 3 years is fewer than 5 and			
therefore a 3-year moving average			
cannot be applied.			
Is the Data Provisional or Final?		Final	Final

Data for reporting year 2012 are calendar year 2011 injuries from the Colorado Hospital Association inpatient data set. Data represent nonfatal injuries to Colorado residents ages 0 through 14. The denominator represents the 2011 population ages 0 through 14 obtained from the Colorado Health Information Dataset at http://www.chd.dphe.state.co.us/cohid/Default.aspx.

Notes - 2011

Data for reporting year 2011 are calendar year 2010 injuries from the Colorado Hospital Association inpatient data set. Data represent nonfatal injuries to Colorado residents ages 0 through 14. The denominator represents the 2010 population ages 0 through 14 obtained from the Colorado Health Information Dataset at http://www.chd.dphe.state.co.us/cohid/Default.aspx.

Notes - 2010

Data for reporting year 2010 are calendar year 2009 from the Colorado Hospital Association inpatient data set. Data represent nonfatal injuries to Colorado residents ages 0 through 14. The denominator represents the 2009 population ages 0 through 14 obtained from the Colorado Health Information Dataset at http://www.cdphe.state.co.us/cohid/.

Narrative:

The rate of non-fatal injuries due to motor vehicle crashes for children 14 and younger decreased to 19.0 per

100,000 in 2012 from the previous year's rate of 19.5. This is the second time this rate has fallen below 20.0 per

100,000, a 44 percent drop from 2004 when the rate was 35.1 per 100,000.

Health Status Indicators 04C: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

Health Status Indicators Forms for HSI 04C - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	140.6	130.6	124.5	102.5	107.4
Numerator	1035	977	932	705	741
Denominator	736038	748317	748829	688090	689811
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2012

Data for reporting year 2012 are calendar year 2011 injuries from the Colorado Hospital Association inpatient data set. Data represent nonfatal injuries to Colorado residents ages 15

through 24. The denominator represents the 2011 population ages 15 through 24 obtained from the Colorado Health Information Dataset at http://www.chd.dphe.state.co.us/cohid/Default.aspx.

Notes - 2011

Data for reporting year 2011 are calendar year 2010 injuries from the Colorado Hospital Association inpatient data set. Data represent nonfatal injuries to Colorado residents ages 15 through 24. The denominator represents the 2010 population ages 15 through 24 obtained from the Colorado Health Information Dataset at http://www.chd.dphe.state.co.us/cohid/Default.aspx.

Notes - 2010

Data for reporting year 2010 are calendar year 2009 from the Colorado Hospital Association inpatient data set. Data represent nonfatal injuries to Colorado residents ages 15 through 24. The denominator represents the 2009 population ages 15 through 24 obtained from the Colorado Health Information Dataset at http://www.cdphe.state.co.us/cohid/.

Narrative:

The injury hospitalization rate among youth ages 15 through 24 years increased in 2012 to 107.4 per 100.000

compared to the 2011 rate of 102.5. Despite the one-year increase, the 2012 injury hospitalization rate continues a

decline since 2004 when the rate was 175.5 per 100,000.

Health Status Indicators 05A: The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.

Health Status Indicators Forms for HSI 05A - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	25.4	28.3	27.8	28.8	29.5
Numerator	4437	4989	4913	4725	4983
Denominator	174660	176095	176549	164015	168756
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2012

Data for reporting year 2012 are calendar year 2011 cases from the STI/HIV Section at CDPHE. Population estimates for 2011 are from the Colorado State Demography Office.

Notes - 2011

Data for reporting year 2011 are calendar year 2010 cases from the STI/HIV Section at CDPHE. Population estimates for 2010 are from the Colorado State Demography Office.

The annual indicator increased slightly because the denominator decreased after adjustments were made to the population estimates based on the 2010 census results. This age group was most affected by the population updates.

Notes - 2010

Data for reporting year 2010 are from the CDPHE NETTS data transfer to CDC and are provisional for 2009. Population estimates for 2009 are from the Colorado State Demography

Office.

The annual indicator and numerator for reporting year 2009 was incorrect because it represented total cases (males, females, and unknown), not just females. The data was corrected for reporting year 2009.

Narrative:

In 2012, the reported Chlamydia rate for women ages 15 through 19 reached the highest rate (29.5 per 1,000)

since it was first included in this grant in 1997, when the rate was 17.0 per 1,000. The number of cases in 2012

increased from the number of reported cases in 2011 and is comparable to the numbers reported in 2009 and 2010.

Health Status Indicators 05B: The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

Health Status Indicators Forms for HSI 05B - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	9.3	9.9	10.8	10.6	12.0
Numerator	7948	8499	9357	9128	10459
Denominator	855855	861987	862929	864846	868672
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2012

Data for reporting year 2012 are calendar year 2011 cases from the STI/HIV Section at CDPHE. Population estimates for 2011 are from the Colorado State Demography Office.

Notes - 2011

Data for reporting year 2011 are calendar year 2010 cases from the STI/HIV Section at CDPHE. Population estimates for 2010 are from the Colorado State Demography Office.

Notes - 2010

Data for reporting year 2010 are from the CDPHE NETTS data transfer to CDC and are provisional for 2009. Population estimates for 2009 are from the Colorado State Demography Office.

The annual indicator and numerator for reporting year 2009 was incorrect because it represented total cases (males, females, and unknown), not just females. The data was corrected for reporting year 2009.

Narrative:

In 2012, the Chlamydia rate for women ages 20 through 44 increased to 12.0 per 1,000 compared the previous

year's rate of 10.6 per 1,000. This is the highest rate of chlamydia for this age group since it was

Health Status Indicators 06A: Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	66568	58942	3877	1360	2389	0	0	0
Children 1 through 4	273343	241178	16154	5577	10434	0	0	0
Children 5 through 9	350398	309463	19596	7236	14103	0	0	0
Children 10 through 14	337487	298550	18727	7246	12964	0	0	0
Children 15 through 19	346288	306318	19666	8045	12259	0	0	0
Children 20 through 24	341685	303962	17651	6874	13198	0	0	0
Children 0 through 24	1715769	1518413	95671	36338	65347	0	0	0

Notes - 2014

Narrative:

Colorado has a population of over 1.7 million under the age of 25, with nearly 1.4 million under age 20. The Black

population is small, with fewer than 100,000 (less than six percent of the total population) under age 25. American

Indian and Native Alaskans number 36,000 and Asians total almost 65,000; all minority groups are relatively small.

However, when the Hispanic population (included in the White totals) is broken out, it totals nearly 464,000 and

comprises 27 percent of the population under the age of 25.

The state population under age 25 fell by approximately 30,000 from 2011 to 2012, a decline of about two percent.

Health Status Indicators 06B: Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	38430	20512	0
Children 1 through 4	157771	83406	0
Children 5 through 9	206850	102613	0

Children 10 through 14	205653	92897	0
Children 15 through 19	219394	86923	0
Children 20 through 24	226473	77489	0
Children 0 through 24	1054571	463840	0

Narrative:

Colorado has a population of over 1.7 million under the age of 25, with nearly 1.4 million under age 20. The Black

population is small, with fewer than 100,000 (less than six percent of the total population) under age 25. American

Indian and Native Alaskans number 36,000 and Asians total almost 65,000; all minority groups are relatively small.

However, when the Hispanic population (included in the White totals) is broken out, it totals nearly 464,000 and

comprises 27 percent of the population under the age of 25.

The state population under age 25 fell by approximately 30,000 from 2011 to 2012, a decline of about two percent.

Health Status Indicators 07A: Live births to women (of all ages) enumerated by maternal age and race. (Demographics)

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Women < 15	64	52	7	0	0	0	0	5
Women 15 through 17	1362	1133	93	27	6	0	0	103
Women 18 through 19	3325	2755	256	64	37	0	0	213
Women 20 through 34	49568	42655	2559	474	1844	0	0	2036
Women 35 or older	10729	9324	392	64	599	0	0	350
Women of all ages	65048	55919	3307	629	2486	0	0	2707

Notes - 2014

Total live births for all races may not add up to total deliveries in the state from Form 8 (65,052) because the age of the mother was unknown for some live births.

Births numbering 1 or 2 in any specific age and race category are suppressed due to state confidentiality rules. These numbers have been added to the other/unknown category in order to report the correct totals.

Narrative:

The number of births in Colorado was 65,048 in 2012, a decline of 1,290 (two percent) from 66.338 in 2011. This is

the fourth year that the number of births was smaller than the previous year. A majority of the decline occurred

among young women under 20, among whom there were 728 fewer births (4,751 compared to 5,479). Births among

all racial and ethnic groups were lower in 2011 than the previous year except for Asians where the totals were

virtually identical in both years. Births among Hispanics comprised approximately 29 percent of all births.

An MCH Issue Brief, "Unintended Pregnancy in Colorado," provides additional information on pregnancy and births in

the state (see section II. C. Needs Assessment Summary).

Health Status Indicators 07B: Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Women < 15	16	47	0
Women 15 through 17	501	842	19
Women 18 through 19	1644	1663	18
Women 20 through 34	35739	13519	310
Women 35 or older	8432	2227	67
Women of all ages	46332	18298	414

Notes - 2014

Narrative:

The number of births in Colorado was 65,048 in 2012, a decline of 1,290 (two percent) from 66,338 in 2011. This is

the fourth year that the number of births was smaller than the previous year. A majority of the decline occurred

among young women under 20, among whom there were 728 fewer births (4,751 compared to 5,479). Births among

all racial and ethnic groups were lower in 2011 than the previous year except for Asians where the totals were

virtually identical in both years. Births among Hispanics comprised approximately 29 percent of all births.

An MCH Issue Brief, "Unintended Pregnancy in Colorado," provides additional information on pregnancy and births in

the state (see section II. C. Needs Assessment Summary).

Health Status Indicators 08A: Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	362	301	43	4	9	0	0	5
Children 1 through 4	57	44	8	3	0	0	0	2
Children 5 through 9	45	35	4	0	5	0	0	1
Children 10 through 14	42	37	4	0	0	0	0	1
Children 15 through 19	158	141	11	3	0	0	0	3
Children 20 through 24	318	272	31	7	5	0	0	3
Children 0 through 24	982	830	101	17	19	0	0	15

Notes - 2014

Data for reporting year 2012 are calendar year 2011 deaths. Deaths numbering 1 or 2 in any specific age and race category are suppressed due to state confidentiality rules. These numbers have been added to the other/unknown category in order to report the correct totals.

Narrative:

There were a total of 982 deaths in the population below age 25 in 2012. The largest number of deaths was among

infants (362) and the second largest was in the age group 20 to 24 (318). Deaths among Hispanics totaled 297 (30

percent), while deaths among the Black population were 101 (10 percent of all deaths), a relatively high number and

percent compared to their presence in the population.

An MCH Issue Brief, "Infant Mortality in Colorado," provides more information on deaths among infants under age

one (see section II. C. Needs Assessment Summary).

Health Status Indicators 08B: Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)

HSI #08B - Demographics (Total deaths)

<u>CATEGORY</u>	Total NOT Hispanic or	Total Hispanic or	Ethnicity Not
Total deaths	Latino	Latino	Reported
Infants 0 to 1	229	128	5
Children 1 through 4	35	22	0
Children 5 through 9	31	14	0
Children 10 through 14	28	14	0

Children 15 through 19	117	40	1
Children 20 through 24	239	79	0
Children 0 through 24	679	297	6

Narrative:

There were a total of 982 deaths in the population below age 25 in 2012. The largest number of deaths was among

infants (362) and the second largest was in the age group 20 to 24 (318). Deaths among Hispanics totaled 297 (30

percent), while deaths among the Black population were 101 (10 percent of all deaths), a relatively high number and

percent compared to their presence in the population.

An MCH Issue Brief, "Infant Mortality in Colorado," provides more information on deaths among infants under age

one (see section II. C. Needs Assessment Summary).

Health Status Indicators 09A: Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown	Specific Reporting Year
All children 0 through 19	1374084	1214450	78020	29464	52150	0	0	0	2012
Percent in household headed by single parent	26.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2012
Percent in TANF (Grant) families	2.0	0.5	2.5	1.2	0.9	0.0	0.0	0.0	2012
Number enrolled in Medicaid	484883	112115	33058	6057	7006	2724	0	323923	2012
Number enrolled in SCHIP	126169	39336	6953	1906	2970	578	0	74426	2012
Number living in foster home care	18034	0	0	0	0	0	0	18034	2012
Number enrolled in food stamp program	95780	0	0	0	0	0	0	95780	2012
Number enrolled in WIC	80093	45449	5966	21298	1651	483	5236	10	2012

Rate (per 100,000) of juvenile crime arrests	2766.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2012
Percentage of high school drop- outs (grade 9 through 12)	4.2	2.7	6.0	8.8	2.3	4.0	2.4	0.0	2012

Data for reporting year 2012 are calendar year 2011 from the Colorado State Demography Office.

Data for reporting year 2012 are from the 2011 American Community Survey 1 year estimates table B09002 "own children under 18 years by family type and age." Race and ethnicity are not available.

Data for reporting year 2012 represent the monthly caseload for December 2012. Data are available from

https://www.acf.hhs.gov/sites/default/files/ofa/2012children_tan.pdf?nocache=1358960078. Source: US Department of Health and Human Services Administration for Children and Families. Racial and ethnic breakdowns are from the Colorado Department of Health Care Policy and Financing.

Data for reporting year 2012 represent federal fiscal year 2012. The Colorado Department of Health Care Policy and Financing provided race distribution which was applied to the FFY2012 number of children ever enrolled in Medicaid from http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/FY-2012-Childrens-Enrollment-04_09_13.pdf.

Data for reporting year 2012 represent federal fiscal year 2012. The Colorado Department of Health Care Policy and Financing provided race distribution which was applied to the FFY2012 number of children ever enrolled in CHIP from http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/FY-2012-Childrens-Enrollment-04 09 13.pdf.

The number shown is the count of households (not persons) with children under age 18 that are receiving food stamps in 2011 according to the American Community Survey table S2201. Data are not available by race or ethnicity.

Data for reporting year 2012 represent WIC infants and children ages 0-5 who were vouchered WIC participants in March 2013.

Data for reporting year 2012 are calendar year 2011 obtained from the Colorado Bureau of Investigation. The 2010 population count for ages 0-17 for the denominator is from the Colorado State Demography Office. Race and ethnicity are not available.

Data for reporting year 2011 represent the 2010-2011 school year. Data include alternative high schools. Data are available from the Colorado Department of Education.

Data for reporting year 2012 were obtained from the Colorado Department of Health Care Policy and Financing FY11-12 Premiums, Expenditures, and Caseload Reports at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1209635766663. Race and ethnicity are not available.

Narrative:

One-quarter (26 percent) of children in Colorado live in a household headed by a single parent. Two percent of

children are in TANF families and a little more than one percent of children are living in foster home care. More than

four out of every ten Colorado children are enrolled in Medicaid; about one in ten children were enrolled in the

Colorado Child Health Plan Plus (CHP+) program at some point during state fiscal year 2012. Enrollment in CHP+ is

at its highest level since the program began in 1997.

A total of 95,780 households with children under age 18 were receiving food stamp benefits in 2011 according to

American Community Survey data. No breakdown by race or ethnicity is available.

The percentage of high school drop-outs is 4.2, down from 4.4 in last year's grant. The highest rates continue to be

found among American Indian/Native Alaskan, Black, and Hispanic adolescents.

Data on children by race or ethnicity are not available for the percent in household headed by a single parent,

number living in foster home care, number enrolled in food stamp program, or the rate of juvenile crime arrests.

Information is available, however, on the percentages in TANF families, where the highest rates are found among

Hispanic and Black children.

A higher number of Hispanic compared to non-Hispanic children in Colorado are enrolled in Medicaid, but ethnicity

was not reported for almost 148,000 children. The number of children enrolled in the Colorado Child Health Plan Plus

(CHP+) is higher for non-Hispanics compared to Hispanics. Ethnicity was not reported for almost 28,000 children in

this program.

Children are only eligible for WIC until age five. A higher number of Hispanic than non-Hispanic children ages zero to

four were enrolled in WIC.

Health Status Indicators 09B: Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY	Total NOT Hispanic or	Total Hispanic or	Ethnicity Not Reported	Specific Reporting
HISPANIC ETHNICITY	Latino	Latino		Year
All children 0 through 19	828098	386352	0	2012
Percent in household headed by single parent	0.0	0.0	26.0	2012
Percent in TANF (Grant) families	1.2	2.9	0.0	2012
Number enrolled in Medicaid	160959	175945	147978	2012
Number enrolled in SCHIP	51743	46430	27996	2012
Number living in foster home care	0	0	18034	2012

Number enrolled in food stamp program	0	0	95780	2012
Number enrolled in WIC	35240	44843	10	2012
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	2766.0	2012
Percentage of high school drop- outs (grade 9 through 12)	3.1	7.0	0.0	2012

The total number of children shown as "Total NOT Hispanic or Latino" and "Total Hispanic or Latino" were determined using proportions derived from American Community Survey 1-year estimates for 2011 applied to Colorado State Demography Office total population estimates by age for 2011.

Data for reporting year 2012 are from the 2011 American Community Survey 1 year estimates table B09002 "own children under 18 years by family type and age." Race and ethnicity are not available.

Data for reporting year 2012 represent the monthly caseload for December 2012. Data are available from

https://www.acf.hhs.gov/sites/default/files/ofa/2012children_tan.pdf?nocache=1358960078. Source: US Department of Health and Human Services Administration for Children and Families. Racial and ethnic breakdowns are from the Colorado Department of Health Care Policy and Financing.

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Data for reporting year 2012 represent federal fiscal year 2012. The Colorado Department of Health Care Policy and Financing provided ethnic distribution which was applied to the FFY2012 number of children ever enrolled in CHIP from http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/FY-2012-Childrens-Enrollment-04_09_13.pdf.

The number shown is the count of households (not persons) with children under age 18 that are receiving food stamps in 2011 according to the American Community Survey table S2201. Data are not available by race or ethnicity.

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number living in foster home care, number enrolled in food stamp program, or the rate of juvenile crime arrests.

Information is available, however, on the percentages in TANF families, where the highest rates are found among

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was not reported for almost 148,000 children. The number of children enrolled in the Colorado Child Health Plan Plus

(CHP+) is higher for non-Hispanics compared to Hispanics. Ethnicity was not reported for almost 28,000 children in

this program.

Children are only eligible for WIC until age five. A higher number of Hispanic than non-Hispanic children ages zero to

four were enrolled in WIC.

Health Status Indicators 10: Geographic living area for all children aged 0 through 19 years.

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	1054484
Living in urban areas	1054484
Living in rural areas	288700
Living in frontier areas	30900
Total - all children 0 through 19	1374084

Notes - 2014

Data for reporting year 2012 are from the 2011 American Community Survey. Metropolitan areas include Boulder, Colorado Springs, Denver-Aurora-Broomfield, Fort Collins-Loveland, Grand Junction, Greeley and Pueblo.

Data for reporting year 2012 are from the 2011 American Community Survey. Urban areas are not delineated in the 2011 American Community Survey, so the value shown under urban areas is the same as the number shown for metropolitan areas.

Data for reporting year 2012 are from the 2011 American Community Survey. The rural area population is determined by subtracting children living in metropolitan areas from the total state population.

Data for reporting year 2012 are from the 2011 American Community Survey. Frontier areas are defined as the 23 counties with fewer than 6 persons per square mile in 2011: Baca, Bent, Cheyenne, Costilla, Custer, Dolores, Gunnison, Hinsdale, Huerfano, Jackson, Kiowa, Kit Carson, Las Animas, Lincoln, Mineral, Moffat, Rio Blanco, Saguache, San Juan, San Miguel, Sedgwick, Washington, and Yuma.

Narrative:

Over one million Colorado children live in urban areas, but a substantial number, nearly 300,000, live in rural areas.

Just two percent, 30,900, live in frontier areas, which are counties with fewer than six people per square mile.

Health Status Indicators 11: Percent of the State population at various levels of the federal poverty level.

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	5118529
Percent Below: 50% of poverty	6.1
100% of poverty	9.9
200% of poverty	31.3

Notes - 2014

Data are from the American Community Survey 2011 1 year estimates, table B17002, ratio of income to poverty level in the past 12 months.

Narrative:

About one in 16 Colorado residents (6.1 percent) lives below 50 percent of the federal poverty level, one in ten (9.9

percent) lives below 100 percent of the federal poverty level, and three out of every ten (31 percent) lives below

200 percent of the federal poverty level. These figures represent a slight improvement from the previous year for

residents living below 100 percent of poverty, when the percentage was 13.4.

Health Status Indicators 12: Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.

HSI #12 - Demographics (Poverty Levels)

Tier with Demographies (1 everty Levels)					
Poverty Levels	Total				
Children 0 through 19 years old	1374084				

Percent Below: 50% of poverty	8.1
100% of poverty	17.9
200% of poverty	39.8

Data are 2011 population data from the Colorado State Demography Office. Data represent children ages 0 through 19.

Data are from the American Community Survey 2011 1 year estimates, table B17024, age by ratio of income to poverty level in the past 12 months. Data represent children under age 18.

Data are from the American Community Survey 2011 1 year estimates, table B17024, age by ratio of income to poverty level in the past 12 months. Data represent children under age 18.

Data are from the American Community Survey 2011 1 year estimates, table B17024, age by ratio of income to poverty level in the past 12 months. Data represent children under age 18.

Narrative:

Almost one out of every twelve (8.4 percent) Colorado children lives below 50 percent of the federal poverty level, a

slight increase from the previous year when the figure was one in 13 (7.5 percent). Nearly one in six (17.9 percent)

lives below 100 percent of poverty and four in ten (39.8 percent) live below 200 percent of the federal poverty level.

While the proportion living below 200 percent is virtually the same as last year, when it was 38.6 percent, the

distribution within the group has shifted downward.

F. Other Program Activities

The majority of MCH Block Grant supported programs have been addressed within the report, below are two

programs not previously discussed in the measures.

The Family Healthline

The Family Healthline is an information referral helpline sponsored by the MCH Program and managed by the

contractor Maximus. The Healthline assists women, families, and individuals in locating free or low-cost health care

services. Information is provided about other programs such as emergency shelters, food subsidies, mental health,

or parenting support groups. The Healthline specialists speak fluent Spanish and English, and arrangements are

made for assisting the hearing-impaired and callers who speak other languages.

The phone line received 10,969 calls from October 2008 to September 2009, approximately 500 more calls than the

previous year. The Family Healthline specialists make referrals, usually within each caller's own community. The

Healthline's referral network covers many categories: low-cost or free medical care, dental health services, domestic

violence counseling, and other basic subsistence resources.

Fourteen percent of the calls were answered on the Spanish line. Maximus also maintained an average call

abandonment rate (the proportion of calls not answered) of 6.13 percent, far less that the standard of 10 percent.

The majority of the referrals requests are for WIC office information, with most calls for services benefitting

individuals under age 25. Ninety-five percent of callers speak English with 43 percent indicating that they do not

have health insurance.

Assuring Better Child Health and Development Project (ABCD)

The CASH and HCP Units are working to implement the Assuring Better Child Health and Development Project that

focuses on promoting the use of standardized developmental screening tools in primary health care settings to help

increase early identification of developmental concerns. The project is supported by the MCH Block Grant and funds

from Colorado-based private foundations. The program manager and a trainer for the project is housed at the

Arapahoe County Early Childhood Education Council and personnel are working with 25 counties to increase the use

of developmental screenings.

/2012/ The Family Healthline received 8,139 calls from October 2009 to September 2010. Thirteen percent of the

calls were answered on the Spanish line. Maximus also maintained an average call abandonment rate (the

proportion of calls not answered) of 6.11 percent, far less that the standard of 10 percent. The majority of the

referrals requests are for WIC office information, with most calls for services benefitting individuals under age 21.

Ninety-two percent of callers speak English with 46 percent indicating that they do not have health insurance.

//2012//

/2013/ The Family Healthline received 6,954 calls from October 2010 to September 2011. Eleven percent of the calls

were answered on the Spanish line. Maximus also maintained an average call abandonment rate (the proportion of

calls not answered) of 6.23 percent, far less that the standard of 10 percent. The majority of the referrals requests

are for WIC office information, with most calls for services benefitting individuals under age 21. Ninety-one percent

of callers speak English with 57 percent indicating that they do not have health insurance. //2013//

/2014/ The Family Healthline received 8,444 calls from October 2011 to September 2012. Ten percent of the calls

were answered on the Spanish line. Maximus also maintained an average call abandonment rate (the proportion of

calls not answered) of 7.37 percent, far less that the standard of 10 percent. The majority of the referrals requests

are for WIC office information, with most calls for services benefiting individuals aged 19-40. Forty percent of callers

indicated that they do not have health insurance. //2014//

G. Technical Assistance

Colorado's technical assistance need is shown on Form 15. The program is seeking assistance in evaluating systems building initiatives.

/2012/ For FY 2012, the program is seeking assistance in learning about other states' strategies for early childhood obesity prevention. //2012//

 $\ensuremath{/}2013\ensuremath{//}$ For FY2013, the program is seeking assistance with measuring progress towards incorporating the Life

Course model into MCH programming. We would like to request the development of a national set of Life Course

measures instead of every state developing their own. //2013//

/2014/ For FY2014, the program is seeking assistance on developing a systems approach to Affordable Care Act (ACA) implementation. //2014//

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2	2012	FY 2	2013	FY 2	2014
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal	7236694	7115761	7178335		7110848	
Allocation						
(Line1, Form 2)						
2. Unobligated	0	0	0		0	
Balance						
(Line2, Form 2)						
3. State Funds	5427521	5336821	5383752		5333136	
(Line3, Form 2)						
4. Local MCH	0	0	0		0	
Funds						
(Line4, Form 2)						
5. Other Funds	0	0	0		0	
(Line5, Form 2)						
6. Program	0	0	0		0	
Income						
(Line6, Form 2)						
7. Subtotal	12664215	12452582	12562087		12443984	
8. Other	93663980	140843100	138573144		141360596	
Federal Funds						
(Line10, Form						
2)						
9. Total	106328195	153295682	151135231		153804580	
(Line11, Form						
2)						

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2012		FY 2013		FY 2014	
I. Federal-State MCH Block Grant Partnership	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
a. Pregnant Women	2321893	2842489	1750000		2508392	
b. Infants < 1 year old	0	0	0		0	

c. Children 1 to	4295272	3903700	4350000	4573616
22 years old	4293272	3903700	4330000	4573010
d. Children with	5527472	4998212	5550000	4658932
Special				
Healthcare				
Needs				
e. Others	0	0	0	0
f.	519578	708181	912087	703044
Administration				
g. SUBTOTAL	12664215	12452582	12562087	12443984
		r the control	of the person	n responsible for administration of
the Title V progra				
a. SPRANS	0		0	0
b. SSDI	75492		86947	72480
c. CISS	118124		151704	101803
d. Abstinence	0		0	0
Education				
e. Healthy Start	0		0	0
f. EMSC	0		0	0
g. WIC	88324209		120524907	121242694
h. AIDS	0		0	0
i. CDC	1040539		11715654	12504576
j. Education	0		0	0
k. Home	0		0	0
Visiting				
k. Other				, , , , , , , , , , , , , , , , , , , ,
ACA-ECVP			302272	0
ACF-CBCAP			728188	0
HRSA	468930		1083056	3186103
SAMSHA				488624
TITLE X			3980416	3764316
ACA - Early	4310			
Childhoo				
ACF - CBCAP	481836			
SAMSHA-Proj	312715			
Safety N				
Title X	2837825			

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2012		FY 2013		FY 2014	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health	420000	327908	1200000		0	
Care Services						
II. Enabling	3300000	1991359	1900000		2156086	
Services						
III. Population-	3400000	2260763	3297531		2034000	
Based Services						
IV. Infrastructure	5544215	7872552	6164556		8253898	
Building Services						
V. Federal-State	12664215	12452582	12562087		12443984	
Title V Block						
Grant Partnership						

|--|

A. Expenditures

Information on annual expenditures is contained in Form 3, Form 4, and Form 5.

2011 MCH expenditures (not including match) were allocated 9.95% to Administration; 34.86% to Children with Special Health Care Needs; 37.99% to Child and Adolescent and 17.20% to Maternal and Infant Services.

Form 3

Line 1 - Federal Allocation -- The Federal allocation award in FY 2011 was less than budgeted for the year by \$120,933,786. (\$7,236,694 vs. \$7,115,761).

Line 4 -- Local MCH Funds -- Local funds from MCH partners were not utilized for match purposes. State funding was sufficient; therefore match was wholly from State funds.

Line 8 - Other Federal Funds -- The variation between projected budget and expended (\$93,663,980 vs. 140,843,100) is mainly due to the three following funding reasons:

- 1. Under estimation of the Women, Infants & Children (WIC) and Child & Adult Care Food Program (CACFP) expensing variance of ~\$31,502,344
- 2. The MCH Director responsible for the administration of the Title V program assumed management of additional programs majorly funded from the CDC. A variance of ~\$11,147,795 3. An under estimation of Title X Family Planning funding by ~ \$1,142,591.

Form 4

Line 1. a. - Pregnant Women -- Budgeted vs. expended - Increase is due to utilization of a state match source not previously used to match the MCH Block Grant prior to 2012 - Family Planning.

Line 1. c. - Children age 1 to 22 - Budgeted vs. expended -- Budgeted vs. expended did not substantially vary.

Line 1. d. Children with special health care needs - Budgeted vs. expended did not substantially vary.

Line 1. f. Administration -- The formula to calculate administrative costs has been reviewed and updated to expense a proportionate, fair and equitable share of the MCH administrative costs to the current Division administrative cost pool.

Form 5

Line 1 - The Colorado MCH program has been working at both the state and local levels to decrease the amount of Block Grant funding spent on direct health care services in order to increase effort at the infrastructure building level.

Line II - Enabling Services - The Colorado MCH program has been working at both the state and local levels to decrease the amount of Block Grant funding spent on enabling services in order to increase effort at the infrastructure building level. The state feels that a great proportion of the total MCH population is served with this approach.

Line III -- Population-Based Services -- Budgeted vs. expended - The Colorado MCH program has been working at both the state and local levels to increase the amount of Block Grant funding spent on infrastructure building efforts, therefore, efforts in the population based services has decreased.

Line IV -- Infrastructure Building Services - Budgeted vs. expended - The Colorado MCH program has been working at both the state and local levels to increase the amount of Block

Grant funding spent on infrastructure building efforts, therefore, efforts in the direct, enabling and population based services has decreased.

B. Budget

Budget information is contained in Forms 2, 4, 5, and 10.

Form 2

Line 1 - Federal allocation - is \$7,110,848 for 2014. Of these dollars, a total of 38.1% (\$2,709,172) will be allocated for preventive and primary care for children; 33.94% (\$2,413,566) for children with special health care needs, and 9.89% (\$703,044) will be spent on administration. These proportions meet the MCH Block Grant requirements.

Line 3 - State MCH Funds - is \$5,333,136 meeting the minimum match requirement of 3/4th of the federal allocation.

Line 7 - Total state match - consists of state general funds in the amount of \$5,333,136. State General Fund match sources will come from Health Care Program for Children with Special Needs, School Based Health Centers and Family Planning.

Line 9. g. - Other Federal Funds - WIC - funds include \$96,582,535 for Women, Infants & Children: \$24,660,159 Child & Adult Care Food Program.

Line 9. i. - Other Federal Funds - Centers for Disease Control - Funding includes BCPPP Rape Prevention, Sudden Infant Death Registry, Early Hearing, Detection and Intervention Surveillance (EHDI), Injury Surveillance, Core II Child Injury Prevention, Sexual Violence Prevention, Womens Wellness, Diabetes Prevention and Control, Colorectal Cancer, Comprehensive Cancer, Cancer Registry, Obesity Prevention, Quitline, Chronic Disease and Self Management, Tobacco Education and Prevention/Healthy Communities Tobacco Education, Colorado Physical Activity & Nutrition, Heart Disease and Stroke, Sudden Infant Death Registry.

Line 9. k. - Other Federal Funds - Funds include; 12 HRSA funded grants; SAMSHA-Project Safety Net, Title X - Family Planning Program.

Form 4

Line 1. a. - Pregnant Women -- the FY14 projection is budgeted at 9% less than actual FY12 expenditures.

Line 1. c. - Children age 1 to 22 -- the FY14 projection is budgeted at 15% more than actual FY 12 expenditures.

Line 1.d.-Children with Special Healthcare Needs -- the FY14 projection is budgeted to be 7% less than actual FY 12 expenditures.

Line 1. f. Administration -- Total administrative costs for FY13 are estimated to be approximately 5.65% of both Federal and State funds.

Form 5

Line I -- Direct Health Care Services - The Colorado MCH program has been working at both the state and local levels to decrease the amount of Block Grant funding spent on direct health care services in order to increase effort at the infrastructure building level. 0% of the budgeted funds will be used for Direct Health Care Services.

Line II -- Enabling Services - The Colorado MCH program has been working at both the state and local levels to decrease the amount of Block Grant funding spent on enabling services in order to increase effort at the infrastructure building level. 17.3% of the budgeted funds will be used for enabling services.

Line III - Population Based Services - The Colorado MCH program has been working at both the state and local levels to increase the amount of Block Grant funding spent on infrastructure building efforts, therefore, efforts in the population based services has decreased. 16.3% of the budgeted funds will be used for population based services.

Line IV -- Infrastructure Building Services - The Colorado MCH program has been working at both the state and local levels to increase the amount of Block Grant funding spent on infrastructure building efforts, therefore, efforts in the direct, enabling and population based services has decreased. 66.4% of the budgeted funds will be used for infrastructure building services.

Form 10

Line 10.e. - Included in the total for "others" are women of childbearing-age, and in some cases, all of the MCH population, who are reached by population-based MCH efforts; any one category does not apply to these two populations.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.